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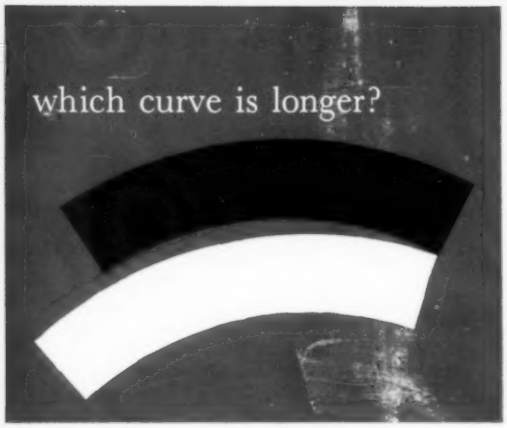
VOLUME 57 NOVEMBER 1961 NUMBER 11



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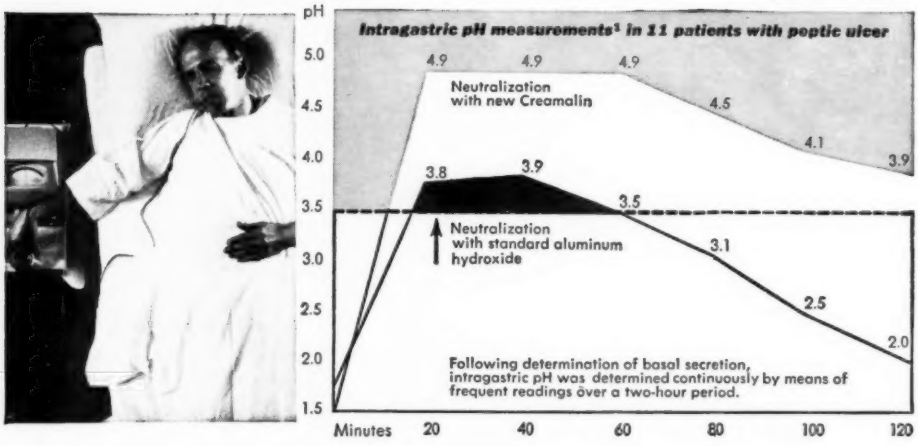

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References: **1.** Schwartz, I. R.: *Current Therap. Res.* 3:29, Feb., 1961. **2.** Beckman, S. M.: *J. Am. Pharm. A.* (Scient. Ed.) 49:191, April, 1960. **3.** Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: *J. Am. Pharm. A.* (Scient. Ed.) 48:381, July, 1959. **4.** Data in the files of the Department of Medical Research, Winthrop Laboratories. **5.** Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: *J. Am. Pharm. A.* (Scient. Ed.) 48:384, July, 1959.

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FOR PEPTIC ULCER • GASTRITIS • GASTRIC HYPERACIDITY

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NOVEMBER, 1961 — VOL. 57 NO. 11

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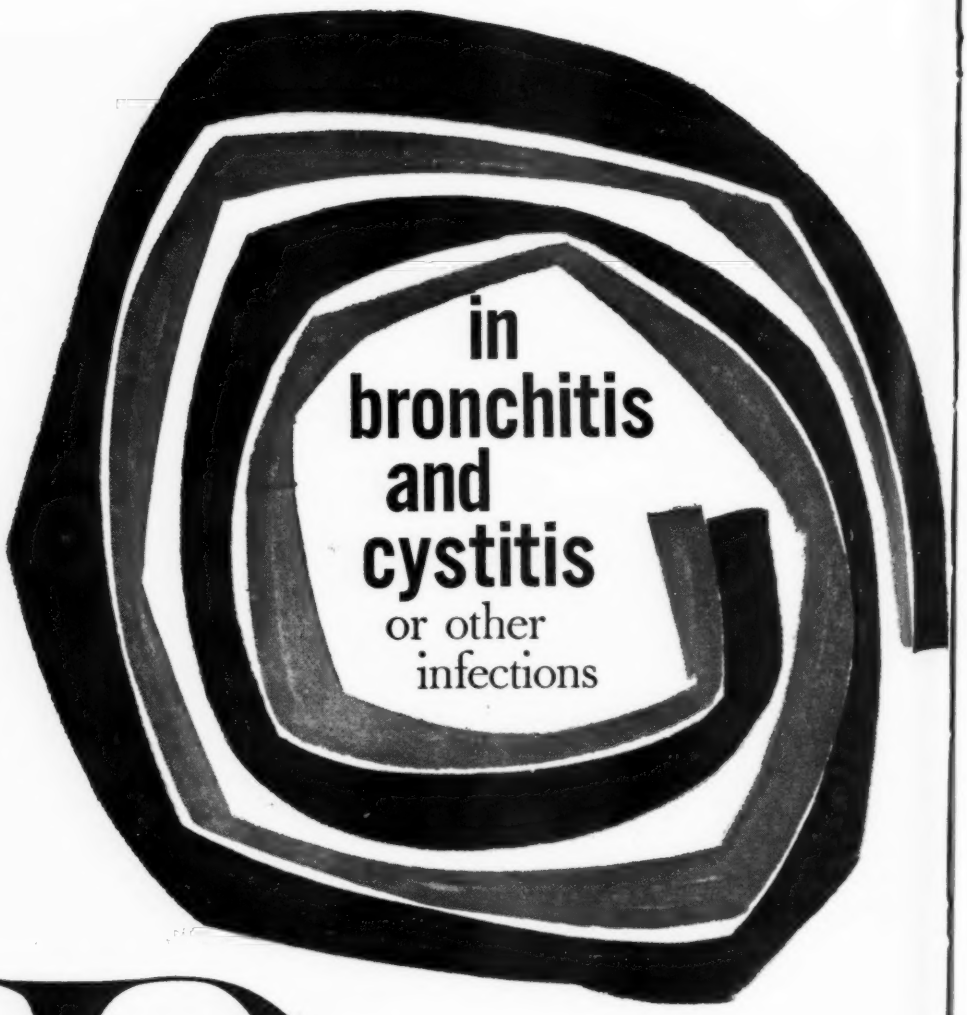

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VOLUME 57 November, 1961 NUMBER 11

PEPTIC ULCERATION OF THE STOMACH AND DUODENUM

ROSS Z. PIERPONT, M. D., F.A.C.S.
Baltimore, Maryland

This subject has been very close to me—in fact, much too close for comfort, for having been a victim of the disease for the past 18 years I speak with some authority on its problems.

I believe firmly that one of the statements made by an old friend, Dr. Paul of the University of Iowa, is, in general, correct. "If you are not half a damn fool in the first place, you never have an ulcer." This is certainly more true in duodenal ulceration where stress appears to be such an important factor. It is no secret to anyone who has been afflicted with this disease that if he is relieved of his responsibilities and pressures, a normal dietary existence with little difficulty is not only possible but probable. Dr. Kirschner of Chicago, relates the problem of a man under his care who had an intractable ulcer with three massive hemorrhages. All manner of medical management failed in this particular case, until the man shed an intractable wife. Following this, the man was *sans* wife and *sans* ulcer.

Such is the evidence of the emotional and stress factors in the production of peptic ulceration. Many other factors are known to all of you—alcoholism, malnutrition, Curlings ulcer in severe burns, etc. However, there are two other factors which have been brought to light more recently; notably the condition described by Ellison and Zollinger which is said to be due to a chemical agent released by a special islet cell tumor of the pancreas, and the ulcer seen in liver cirrhosis in which it is felt that the gastric secretory stimulant from the intestine is not properly inactivated by the liver. Finally, there is the ulcer of steroid therapy.

The pathogenesis of peptic ulceration has received a tremendous impetus from the work of Dr. Lester Dragstedt. It has been he, more than anyone else, who has called our attention to the fact that while peptic ulceration of the stomach and duodenum is in both cases primarily the product of hyperacidity, the pathogenic mechanism of the two ulcers is vastly different.

A brief review of Dr. Dragstedt's concept is in order. It is felt that there are two principal methods of stimulation of the acid secretory mechanism of the stomach. One of these is through nervous stimulation by way of the vagus nerve. The other is by hormonal means through the production of gastrin by the antral portion of the stomach. Further, it is believed that the duodenal ulcer is caused primarily by the vagal nervous mechanism, while conversely the gastric ulcer is caused by the gastrin hormonal mechanism.

The support for this thinking fits in with the many experiments carried on by Dragstedt over a long period, plus the clinical application in the form of patient evaluation with the Dragstedt form of gastric analysis. Briefly described, this consists of the use of a clear liquid diet for the evening meal, followed by

Address to South Carolina Medical Association, Charleston, South Carolina—April 26, 1961.

nasogastric intubation with emptying of the stomach at 7:00 P. M. The patient is then allowed to be as quiet as possible and all secretions are collected during the 12 hour period to 7:00 A. M. At this point, histamine is administered and a second specimen is collected at 9:00 A. M. The first specimen, or night secretion, represents vagal activity and the second specimen hormonal activity.

With a great deal of uniformity, Dragstedt has been able to demonstrate hypersecretion and hyperacidity in the night secretions of the duodenal ulcer patients with a relatively low value for the hormonal phase. The converse has in general been true for the gastric ulcer. Certainly, this is not 100% correct and there are areas where both values are high, etc., but this has been the overall general pattern.

Bearing in mind these foregoing factors, the treatment of peptic ulceration takes on some rational basis. It becomes quite obvious that anything which can be done to relieve the nervous stimulation will most certainly cut down on hypermotility, hypersecretion and hyperacidity in the duodenal ulcer. Hence, the value of phenobarbital and other sedatives and tranquilizers. It is in this area that conceivably psychotherapy could have its greatest effect. Anything that will slow down the central nervous system discharge through the vagus mechanism is of value. The anticholinergics, such as Banthine, Probanthine and the like, have a more direct action on the vagal mechanism itself, but the end result is the same—notably, to cut down the exciting stimuli from the vagus nerve and thus decrease the production of hydrochloric acid.

All of the foregoing have as their rationale one thing in common and that is to cut down the hydrochloric acid production in the stomach. Dietary management has a similar rationale with bland, non-stimulating frequent feedings literally to soak up the secretions of the stomach, neutralize acidity and, perhaps, slow motility. Along with the use of suitable diet, various substances for neutralization of acid in the empty stomach are added. It is generally agreed that the liquid antacids, such as Maalox (Rorer), Amphogel (Wyeth), Fluagel (Breon), etc., are the more satisfactory drugs for administration from the standpoint of pure efficiency of therapy. However, if any of you have had personal experience with this problem, it is perfectly obvious how much more convenient it is to carry a package of pills than a bottle of liquid. Consequently, the flood of the tablet antacids. It has been said that any liquid antacid in proper dosage will protect and buffer almost all of the acid of the stomach for about one and one half hours. However, many of the tablet antacids fall short of this goal. Alglyn (Brayten), which is a brand of dihydroxy aluminum aminoacetate (N.N.R.), has the capacity to reproduce similar results to that of the liquid antacids. The same product is also marketed under the name of Robalate (Robins).

When the ulcer is active, it would appear that the use of the antacid should be on an hourly basis between meals and generously at bedtime, with possibly a dose during sleeping hours by awaking the patient once during the night. Less frequent administration may leave dangerous times for hyperacidity.

Briefly, the medical management lies within combinations of the foregoing. Certainly a patient with a very acute ulcer is best hospitalized with rigid routine. However, the average ulcer is more or less a life-long disability with recurrence and healing progressing intermittently. Some sane rationale of therapy which allows the patient to get along satisfactorily in society and maintain reasonable control of his ulcer seems to be in order. This should be highly individualized. In my opinion, it is worthless to ruin an individual mentally and spiritually, simply to cite the cure of a physical ailment.

The same type of rational thinking can be applied to the surgical treatment of peptic ulceration, which in our hands has been reserved primarily for the complications of the disease.

There is general medical agreement on the prompt closure of perforated ulcer in spite of a small minority who would use gastric suction to treat this complication. Suction therapy alone is a very hazardous procedure to pursue in most situations. The two controlling factors in mortality still continue to be the age of the patient and the time interval from perforation to closure or definitive surgery.

Hemorrhage which is acute is treated in the following manner. If the hemorrhage is an initial one and subsides promptly under usual medical management, and the patient is young, he is evaluated and treated as any other patient with peptic ulceration. If the hemorrhage is repeated, or continuous, or if the individual falls in the older age group—i.e. above 50 years—then surgery is advised; and it is simply a question of proper timing, which is a highly individualized consideration. It should be borne in mind that 60% of all the massive upper gastrointestinal hemorrhages are due to peptic ulceration.

Obstruction, if it is acute, is treated by intermittent gastric suction, rapid institution of proper fluid balance and early surgery. It is especially important here to call attention to the fact that continuous gastric suction in a complete pyloric obstruction can cause irreversible alkalosis to develop very rapidly. If the obstruction is partial, the patient can usually be managed successfully and treated with elective surgery as deemed appropriate.

No longer are there many advocates of a 90% resection, and on the other side of the coin, there are few advocates of simple gastroenterostomy, except in very special circumstances.

What then determines the individual approach to this problem?

With the precepts presented as a foundation, we carefully reviewed our experience with subtotal gastrectomy. This was found disappointing from the standpoint of late complication in the form of post-prandial pain, dumping syndrome, weight loss and anemia.

In spite of the fact that most of the patients were satisfied with their results, it seemed to us that they were frequently pleased that they had traded a greater for a lesser evil.

Mortality was not a factor for consideration in our limited series; but comparatively the mortality is reported as 1 to 3% for vagotomy plus a drainage procedure whereas the mortality is reported to be as much as 5% in gastric resection.

Therefore, beginning in 1953 we adopted vagotomy with drainage as the usual operation for duodenal ulceration as an elective procedure. This has even been extended to include bleeding duodenal ulcer by using simple ligation and oversewing of the bleeding area by duodenotomy in combination with vagotomy and drainage. The results have been encouraging enough to stimulate a reporting at this time. The usual operation is described with the admonition to bear in mind that variations are applicable to specific cases.

The Procedure: An indwelling nasogastric tube is put in place. The abdomen is opened through an upper midline incision and the usual exploration is carried out. If the decision for vagotomy and gastroenterostomy is made, the peritoneum is broken through by blunt dissection to the left of the esophagus. Dissection is carried left to right with careful delineation of the crura of the diaphragm. The right vagus is picked up posteriorly and to the right as a strong cordlike structure and stripped blindly for a short distance (Figs. 1A and 1B). The peritoneum medial to the

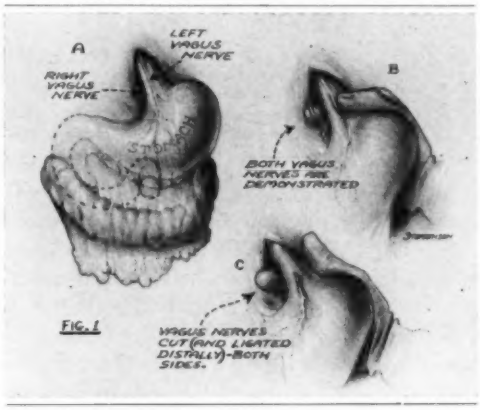

FIG. 1

esophagus is then broken through bluntly and blindly with the forefinger posterior and the thumb anterior. This clears the esophagus everywhere except immediately anteriorly; and this is removed by dissection with a Kelly clamp (Fig. 1B). The entire esophagus can then be delivered into the abdomen for two to three inches. The principal vagus trunks are then easily identified and excised (Fig. 1C). The distal ends are ligated with #00 black silk because of bleeding which may occur. The left vagus trunk must be sought in the muscular wall of the esophagus anteriorly. Any other suspicious strands are divided, thus completing a virtual circumcision of the esophagus.

The site for gastrojejunostomy is selected close to the pylorus, the greater curvature being cleared for a distance of about five to six inches (Fig. 2A). Usually the anastomosis

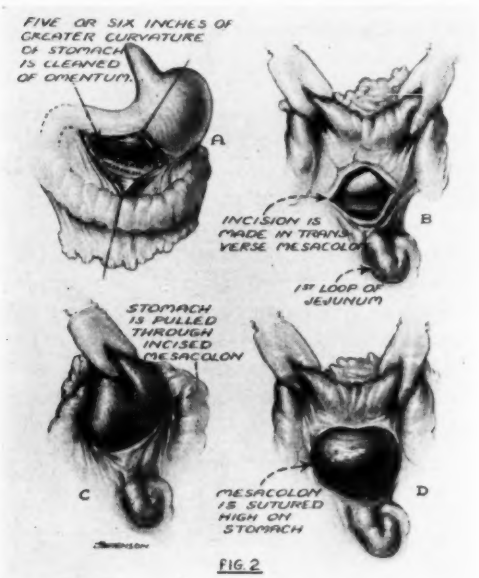

FIG. 2

is placed no further than one and one half inches from the pylorus directly on the greater curvature. This is altered in circumstances of long standing obstruction where the dependent portion of the stomach is more to the left and a different point of actual dependency must be considered. An opening is made through the transverse mesocolon in an avascular area to the left of the middle colic artery (Fig. 2B). The mesocolon is sutured high up on the stomach wall, well away from the area of anastomosis to prevent late constriction (Figs. 2C and 2D). Using fine silk sutures a very short no-loop type of anastomosis is created by suture with two or three fine silk sutures on the antimesenteric border of the jejunum, uniting this to the posterior peritoneum and the posterior stomach wall just distal to the ligament of Treitz (Fig. 3A). The anastomosis is made on the antimesenteric border of the jejunum with the greater curvature of the stomach, from which a circular section is removed about the size of a five cent piece. The jejunum is completed in a conventional two

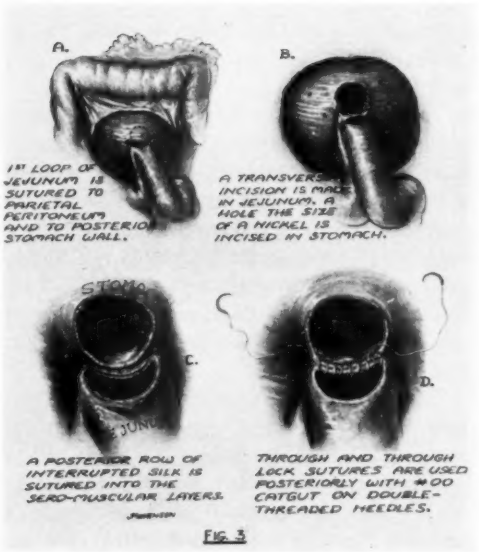

FIG. 3

row anastomosis, by the use of an outer row of interrupted Lembert seromuscular sutures of black silk and an inner row of continuous sutures of posterior lock and anterior Connell sutures of #00 chromic catgut (Figs. 3C and 3D, Figs. 4A and 4B). The abdomen is closed in routine fashion in layers or, in possible anticipated evisceration, with alternating through and through wire and Jones sutures of #1 chromic catgut.

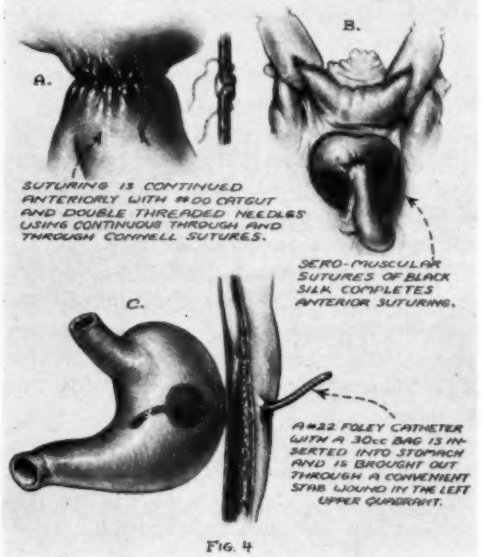

FIG. 4

During the past five years it has been our habit to supplement the operation with a simple tube gastrostomy. A #22 Foley catheter of 30 ml. bag capacity is inserted fairly high up in the anterior wall of the stomach and secured with two pursestring sutures of black silk (Fig. 4C). The outer silk pursestring is secured to the parietal peritoneum at the point of exit of the catheter through the abdominal wall. This is through a separate stab wound in the left upper quadrant. After the pursestring sutures are tied, the bag is inflated with water and the stomach is drawn snugly to the parietal peritoneum (Fig. 4C). The catheter is secured externally by a #32 S.S. wire suture. One word of caution—in introducing the catheter, it should be brought from without in through the abdominal wall and then inserted into the stomach. This seems quite elementary; but we have observed ourselves and others attempting to extricate the drainage end of the Foley catheter through the small stab wound in the abdominal wall—no pleasant task, I assure you.

I believe that no single addition which we have made has brought more comfort to the patients in the postoperative period than this simple method of gastric drainage. Complications have been nil. The procedure affords a much sounder observation if late bleeding or partial obstruction occur. Gastric analysis for efficiency of vagotomy may also be checked as well as gastric retention. I cannot overemphasize its value in the elderly patient.

Postoperative gravity drainage is maintained for 48 hours. The tube is clamped and feeding begun in graduated fashion. Full diet is usually tolerated by the sixth to seventh postoperative day. The tube is removed in six to eight days and drainage rarely occurs and persists.

All of the foregoing has concerned duodenal peptic ulcer management. What about gastric ulcer?

We believe that gastric ulceration in individuals above the age of 45 years, without some mitigating circumstances to contradict surgery, is a surgical lesion. Where practical, with the ulcer in the distal one third of the stomach, a short gastric resection with Billroth I anastomosis or gastrojejunostomy is quite satisfactory. In ulceration in other areas of the stomach, with the issue in doubt as to malignancy, we believe that simple wedge resection of the ulcer with frozen section is indicated. If the lesion is benign, a combination of the wedge resection with gastroenterostomy of the type described is very satisfactory. The path for wide resection, if the ulcer is malignant, is clear. Vagotomy is not usually necessary for gastric ulcer unless the cephalic phase of acidity is high, which is occasionally the case.

The Material: There have been 60 patients treated by surgery using vagotomy in the last six years. Among these, there were 42 males and 18 females in a ratio of 2.3 to 1 with an average age of 50.3 years. The youngest was 19 years and the oldest 73 years. Duodenal ulcer comprised 53 cases with gastric ulcer numbering 4. Three combined duodenal and gastric ulcers completed the list.

TABLE I

SURGICAL PROCEDURE	
Vagotomy and Gastro-enterostomy	48
Vagotomy, Gastrectomy and Gastro-enterostomy	8
Vagotomy, Wedge Resection and Gastro-enterostomy	2
Vagotomy, Pyloroplasty	2

The type of procedure is outlined in Table I indicating that while the vast majority fitted the conformity necessary for vagotomy and gastroenterostomy, the necessity for substitution and the use of other procedures is ever present.

TABLE II

INDICATIONS FOR SURGERY	
Intractable Pain, Refractory to Medical Management	24
Hemorrhage	16
Obstruction	15
Repeated Perforation	5
Note:	
One with Perforation and Hemorrhage	
One with Obstruction and Hemorrhage	

The indications as listed in Table II are essentially those of all series and are not remarkable. Sometimes I think that we are too reluctant to operate earlier on intractable ulcer, but this is purely a matter for debate at present. The procedure has been singularly free from major complications. There have

been no deaths. There was one wound abscess and one deep thrombophlebitis of the leg.

Dumping syndrome, loss of weight and anemia have not been observed. There has been the usual early difficulty with vagotomized patients in about 60%, in the form of flatulence, distention, eructation and diarrhea. This has taken various forms in various individuals. However, all have responded very well to Urecholine (bethanecol chloride) therapy, usually given 15 mg. three times a day, one half hour before meals, and none has persisted longer than three months.

There have been no demonstrable recurrences although admittedly it is early for evaluation. Two patients have been readmitted late to the hospital for symptoms—one four years and one one year following surgery. The first patient proved to have spastic nonspecific colitis which responded to medical management, and the second had esophageal hiatus hernia which was repaired.

Summary

The procedure of vagotomy and gastroenterostomy has been the basic treatment for the elective management of peptic ulcer of the duodenum in our hands during the past six years. During this time 60 patients have been treated with no mortality and a low morbidity.

Conclusions

Vagotomy and gastroenterostomy properly and painstakingly applied offer an excellent method for the elective surgical management of duodenal ulcer and in selected cases of bleeding doudenal ulcer.

The operation is technically easier, gives a lower mortality and leaves less morbidity than gastric resection in our hands.

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External cardiac massage—R. Baringer, E. Salzman, W. Jones, and A. Friedlich. New Engl J Med—265:62 (July 13) 1961.

Closed chest cardiac massage was used in 84 unselected cases of circulatory arrest. The heart was compressed by external pressure applied 60 to 90 times per minute over the lower sternum. The survival rate is largely dependent on the nature of the underlying disease. Effective circulation was maintained with palpable pulses and nondilated pupils in the majority of patients. An effective heart beat was restored in 36 patients. The method permitted electrical defibrillation of the heart in 10 of 18 patients with ventricular fibrillation. Of 23 who survived over 3 hours, 19 died of their underlying disease. Four left the hospital in good health. Postmortem examinations in 46 patients revealed rib fractures in 15 and hepatic trauma in 5. The procedure is effective in maintaining circulation for prolonged periods. It can be used where thoracotomy and open cardiac massage would not be practical.

Congenital cataract: incidence in one family, by C. W. Evatt, M. Alter and Elsie Taber (Charleston) South. M. J. 54:639, June 1961.

There are many causes known and unknown of Congenital Cataract. This article reports on a study extending over a period of seventeen years, embracing four generations of one family where fifteen were born with bilateral cataracts. All except one have been operated on and have useful vision. The unoperated one has 20/25 vision despite small central cataracts in each eye. Ages of operated persons range from four to forty eight years. There were ten males and five females. One had nystagmus and muscle imbalance. Except for cataracts all others were normal.

The effect of consanguinity and of the enzyme systems controlling carbohydrate metabolisms were studied in this family. Various classifications and theories of origin are mentioned in the report. Many congenital cataracts occur sporadically and are therefore due to an agent peculiar to the individual; others occur familially and are therefore probably dependent upon some maternal abnormality, while others are markedly hereditary, being transmitted by the father as well as the mother and therefore in these a germinal cause must be assumed.

Clay W. Evatt

MAJOR EYE SURGERY AS AN OUTPATIENT PROCEDURE

J. W. JERVEY, JR., M. D.

Greenville, S. C.

I gratefully acknowledge the honor done me in according to me this place on your program. All of us in clinical practice are basically scientists and as such we do well to recall what Sir William Osler in his *Aequanimitas* said, "In seeking absolute truth we aim at the unattainable, and must be content with finding broken portions." It is my hope that I have found and can share with you one of these portions.

In recent years there has been a tendency to allow surgical patients up sooner and sooner after operation. Even where the abdomen has been opened, patients are up and around in a few hours. Some severe medical diseases also, such as cases of paralytic stroke, are being treated on an outpatient basis in well recognized clinics.[1] Since the eye is in a peculiarly well adapted area for protection and cannot be kept entirely quiet in any case, it occurred to me many years ago that there was no need to take the then customary excessive care of postoperative eyes. My first paper on this subject was read before the Southern Medical Association in Dallas, Texas, in 1952.[2] There first mention in print was made as to thoughts on the postoperative care of retinal detachment, and I was accused by at least one friend of making this operation an office procedure. He was very nearly right, and I still think I was and am. I had also been gradually relaxing on the postoperative care of cataract extractions as methods of wound closure became exact and effective, and I had long since ceased to take unnecessary care of muscle cases save for ordinary measures of cleanliness.

During the past war, when hospital beds were not available, some of the best known men in this country did of necessity what I am doing now by choice and with great satisfaction. While opportunities to serve in this way may come more regularly to the eye surgeon than to some others, nevertheless surgeons and physicians in general could dispense with hospitalization more often than they do. Those who claim otherwise have closed their eyes to the facts. The specialist has been preaching for years to the general practitioner about what he should or should not do about the eye and many other things. It is about time the tables be turned, and I would suggest to some of my general practice friends that they seriously begin to question how some specialty cases are handled. We often ask the family physician to let us see certain types of cases as early as possible. Why shouldn't he in turn ask that they be cared for and returned home as soon as practicable?

About twelve years ago I removed a cataract from a patient's only eye. He was a heart case and not able to lie down very long. Then he developed a detachment. I put the case to him that he had a condition that would certainly result in blindness if something were not done to prevent it. I explained the situation and told him of the ordinary way in which such cases were handled, but that his only chance lay in surgery, and that I was willing to operate and take the chance of not requiring immobilization afterwards. He agreed. From the time he left the table, he was allowed to sit up and to move about. The result was perfect! I therefore decided that since this man had made a remarkable recovery under admittedly adverse conditions, others could do the same thing. I began cautiously to treat other cases in like manner. Although we do relatively few detachments, our results compare favorably with other reports.[3]

Now as to our management of major eye surgery in general as an outpatient procedure: we have in our own building a well equipped little operating room, as fine as to be found except as to size, which however meets our

Read at the 1961 Meeting of the Association of Surgeons of the Southern Railway System.

needs. We have our own nursing staff, capable and efficient.

In the beginning, I was very cautious in deciding on which case to operate and send home. I discussed the irregularity of the procedure as well as its advantages. It was and is always left up to the patient as to whether he wants to be first admitted to a hospital or done in our surgery and afterwards sent to home or hospital. There are, of course, cases of a complicated nature that should be done only in the hospital. Now, however, in uncomplicated cases, with the backlog of 12 years' experience, the patient is simply told that he may take his choice of several ways of being treated. He usually prefers to be operated on in our surgery and go home.

Where proper precautions are taken, one is in no greater legal danger from caring for a patient at home, than one is from treating him in the hospital. The signed permissions usually required by hospitals are practically worthless, and may even suggest unpleasant possibilities to the patient. They in no way protect the doctor and his staff or the hospital and its staff from suit in the case of negligence or malpractice, and the mere fact of the patient's coming to the office by appointment for surgery is sufficient evidence of willingness and consent. It goes without saying that all patients are properly worked up before surgery, usually in consultation with the family physician, or an internist where indicated, and that rapport between patient and surgeon is of the highest quality.

We have no trouble save for an occasional little known company about the payment of insurance claims for surgery. The companies are, as they should be, glad to pay these claims since otherwise they would have to pay a hospital bill in addition. Some even pay an operating room fee.

Let us follow a patient who has had a cataract extraction and is to go home for postoperative care. By the time the operation is completed an ambulance has arrived. The patient is lifted from the table, though I really believe he might just as well walk save for his sedation, is carried home and put in bed with the head elevated on two or three pillows. As soon as he has reacted from his sedation, he is allowed out of bed, to sit up or go to the bathroom. He may go to the table for meals, and he is allowed to look at television with one or both eyes as long as he can do so without discomfort. I know of no way in which an eye can be held any more nearly immobile than by looking at television from a reasonable distance. Only the operated eye is covered in cataract surgery and, if this is the only eye, a plus ten lens is placed over a hole in a ring mask on the second day after operation so that the patient may have the benefit of vision right from the beginning. This is a most helpful and gratifying procedure. A protective mask is worn at night.

Visitors in general are not welcome for the first few days. With the patient at home, one can obtain better cooperation in keeping them away than he can in the hospital where there are too many outside influences and only too often actual inability to carry out orders. You are all familiar with Monday morning hangover from hordes of Sunday curiosity seekers. At home, I can give orders directly; I can assume the full onus of being a veritable ogre in the interest of my patient and, as a general rule, he is grateful for the respite that is afforded.

After the surgery is completed some responsible member of the family is given a small supply of sterile eye patches which are to be used at home by me or under my direction. Four or five capsules of sodium pentobarbital are given in a small container to be used at night and a few capsules of Phenaphen with codein are supplied in case of pain. These are frequently not needed. We seldom see postoperative nausea or vomiting.

Patients so managed are within reasonable distance and are visited on the day after surgery, the second, and fourth days, after which they return to the office in one week for observation and for removal of sutures. No special care has to be taken at dressings which are done at my convenience before or after office hours, or during the lunch hour. After removing the dressing, the patient is asked to open his eyes. Sterile swabs put up in a paper wrapper and carried with me are used to wipe off the eye if necessary, employing Neosporin drops (polymixin, gramicidin,

and neomycin) which the patient has been using for several days before operation. No attempt is made to clean the conjunctival sac in the average case. All I want to see is that there is no evidence of infection and that the wound is closed. There is nothing more that one can do. After the fifth day, family or patient can change the dressing if needed, though as a rule by this time it can be omitted. Many patients feel that the eye should be cleaned, but it is to be remembered that tears are perhaps the most powerful antiseptic fluid in the body and should not be interfered with. Even so, after four or five days the patient is allowed to sit at his lavatory and apply hot wet towels to the closed operated eye for 20 to 30 minutes or as long as he wishes, several times a day. This affords great comfort and is best done by the patient himself. If there is conjunctival secretion, Neosporin drops are used three times a day as before operation. Protection from light is most comforting and dark glasses are supplied. Atropine is prescribed when indicated. There are no restrictions on diet unless this is medically indicated, and a cathartic of choice may be taken when the patient wishes it. Antibiotics save as above noted are seldom employed.

Glaucoma cases are seen only once at home, the day following surgery, after which they come to the office. The eye is left open after the first 24 hours. They are not required to go home by ambulance.

In all intra-ocular cases, the anterior chamber is reformed either by the natural aqueous flow, which is usual, or by air injection before the patient is removed from the operating table.

Muscle cases have the operated eye covered for 24 hours, but this is probably unnecessary, and when a child objects the dressing may be removed at once or not applied in the first place. Here cold compresses for 20 minutes, if tolerated, may help to reduce postoperative edema. These patients return to the office the day after surgery whether done under local or general anesthesia.

There is no question that the patient, particularly the older patient is much happier at home than in the hospital and, therefore, recovery is more rapid. I have never seen one of these home-treated cases become disoriented. Furthermore, there is less chance of postoperative infection because there is no cross contamination, and the patient is in surroundings to which he is accustomed and to which he has probably become desensitized. Another thing which to me is important, is the opportunity to visit my patient in his home, and there is a good chance to become a friend rather than remain just a technician. I have been deeply touched at times to realize the genuine and deep appreciation of the personal interest shown by accepting an invitation to sit down for a few moments to chat or to enjoy the hospitality of an open fire offered in the finest spirit of friendship and good feeling. Though daily opportunities occur in the office, still greater ones open up in the home to be of real spiritual help, and the mere fact of having the patient cared for in the home lends dignity and worth to the home itself.

Many patients cannot afford prolonged hospitalization, and a few will not submit to it at all. I know that some of my patients have endured surgery and regained eyesight who would not have done so if hospitalization had been required. It is especially important that old people be not disturbed in their ordinary routines. Any of their little personal likes or dislikes should be catered to, and I particularly enquire as to the matter of alcoholic beverages. If an older person, or a younger one for that matter, is accustomed to a highball, or even two, at any time of day, it is well that this not only be allowed but encouraged.

I would not pass over the difficulties involved. This method may not suit your easiest convenience or mine. There may be calls from home that you would not receive if the patient were in a hospital, but they are exceptional; the family may be apprehensive about nursing care and about the appearance of the eye if they are present at the dressing. However, all of these things can be well handled with a small amount of tact and common sense. One point must be watched. Sent home, the patient may gain the idea that the surgery he has had is of little consequence. He must constantly be reminded that because he is allowed home does not mean that he is not to take every

reasonable precaution and to follow orders. Overuse of the eyes or bodily fatigue may prolong and render the recovery period more uncomfortable.

On the purely selfish side of the question, and there is this side, I can almost completely remain the manager and the master of my time. There are few irritating delays, and much valuable time is saved between cases when one can see several patients while waiting for the next case. This is an unadulterated delight.

Wherever major surgery is undertaken, I want a satisfactory answer to three questions: one, do you want the operation? two, do you want me to do it? and three, do you believe it will be successful? I want my patient to have a strong faith in his heart, and not just on his lips. One can usually recognize sincerity. Beware of the over-enthusiastic person as well as the reluctant one. These I should like to go to someone else.

In the past nine years, exclusive of cases done in the hospital, we have operated in our own surgery, on an outpatient basis, on approximately 200 cataracts, 150 muscles, 50 glaucomas, plus several hundred miscellaneous cases of needlings, traumatic repairs, intraocular foreign bodies, tumors, enucleations, and pterygiums. In all these years, I have never seen a complication that could be attributed to the postoperative care of these patients. The few complications which we have had, generally speaking, have been in the hospital cases. This system has been evolved over many years and to it I have given much time, thought, and preparation. I believe it to be safe and sound, and I know it to be satisfactory.

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LEADING CAUSES OF DEATH,
SOUTH CAROLINA
(by occurrence)
Calendar Year 1959

Cause	Total Deaths
Heart	6,429
Intracranial Lesions of Vascular Origin	2,772
Cancer	2,211
All Accidents	1,499
Diseases peculiar to the First Year of Life	1,016
Pneumonia — All Forms	666
Digestive System	663
General Arteriosclerosis	372
Kidneys	359
Diabetes Mellitus	282
Total Leading Causes of Death	16,269
Total All Other Causes of Death	3,218
Total All Causes of Death	19,487

Total Live Births for 1959—59,975
Prepared by:
Bureau of Vital Statistics
South Carolina State Board of Health
Released by:
Maternal and Child Health Division
April, 1961

MEDICAL COLLEGE CLINICS

THE MEDICAL COLLEGE OF SOUTH CAROLINA

ELECTROCARDIOGRAM OF THE MONTH

Myocardial Degeneration in Myasthenia Gravis

DALE GROOM, M. D.
Dept. of Medicine

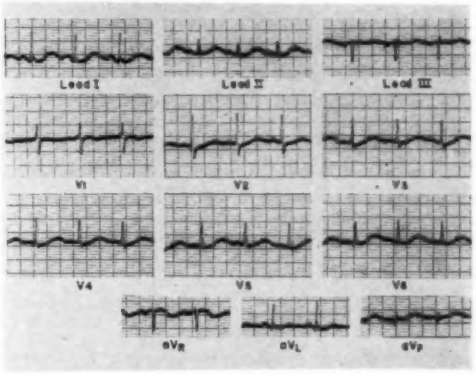
Case Record—A real cardiac rarity is this case of myasthenia gravis with fatty infiltration and degeneration of the myocardium resulting in congestive failure and death.

Neurologically the patient's course was one of typical muscle weakness of minimal degree in the mornings, becoming progressively worse as the day wore on. Symptoms began at age 63 when she first noted transient diplopia, inability to raise her arms over her head, then dysphonia, drooping of the eyelids and finally generalized muscle weakness and dysphagia. Response to treatment with anticholinesterase drugs was reasonably good although considerable difficulty was encountered from gastro-intestinal side effects.

Her cardiac history was somewhat obscured by the more obvious neurologic and G. I. problems. However during the four years from the onset of her illness until death there was mention of substernal pain on exertion and, ultimately, increasing dyspnea, a moderate elevation of blood pressure, congestive failure and a rather sudden demise characterized by chest pain, tachycardia and shock which proved refractory to the usual measures of treatment.

At the time this electrocardiogram was made the patient's serum potassium was normal (4.51 mEq). Several determinations of the potassium, as well as of sodium, chlorides, CO_2 combining power and the blood urea nitrogen were likewise normal on this and previous hospital admissions. Late in the illness moderate cardiac enlargement and atony of the esophagus were noted by the radiologist.

At autopsy the heart weighed 510 grams. The remarkable finding was that of very extensive deposition of fat beneath the epicardial surface with grossly evident replacement of much of the myocardial tissue of both ventricles by fatty infiltration. Microscopic sections prepared with special fat stains disclosed bands and lobules of adult type adipose tissue separating atrophic myocardial muscle fibers and narrowing the diameter of the bundles throughout the entire ventricular wall. A section of papillary muscle showed almost complete replacement by adipose tissue. In the coronary arteries there was a moderate amount of atheromatous plaque formation without any demonstrable thrombosis or occlusion. The heart valves were



grossly normal. Similar deposition of fat was found in the liver which weighed 1300 grams and showed advanced fatty degeneration of lobules, particularly in areas surrounding a central vein. A thymoma was not present nor were any remnants of thymus gland discernible in tissues removed from the mediastinum. Partially organized thrombi were found in secondary branches of the pulmonary arteries of two lobes, with areas of focal atelectasis distal, but the microscopically evident organization and attachment of the thrombi to the intima of the vessels was more indicative of primary thrombosis rather than of pulmonary embolism which was cited clinically as the immediate cause of death. The pathologic diagnosis was fatty infiltration and degeneration, severe, of heart and liver, of a degree sufficient to account for a cardiac death.

Electrocardiogram—The tracing, the only one recorded on this patient, shows remarkably little in contrast to the severity of the pathologic changes in the heart. Amplitude of the QRS complexes is not reduced as one might expect in an infiltrative or atrophic myocardial disease. The electrical axis is horizontal, ventricular depolarization being directed predominantly toward the left arm, but there is no delay in intrinsicoid deflections suggestive of hypertrophy. The appearance of typical left ventricular complexes as far to the right as V-2 is indicative of counter-clockwise rotation of the heart around its long axis.

The conspicuous abnormality in this tracing is the magnitude of the U waves in virtually all leads except V-1 where the T wave is seen to end approximately 0.34 sec. after onset of the QRS.

Discussion—The significance of the prominent U waves here is unknown. Repeated serum potassium determinations ruled out a hypokalemia though conceivably the intracellular level of potassium could have been low. For example, in certain myopathies, as well

as in familial periodic paralysis, the concentration of potassium within the muscle cell is known to become deficient in relation to serum levels but this has not been regarded as a feature of myasthenia gravis. There was no dietary restriction of sodium or potassium, no vomiting, diarrhea or diuretic therapy to account for excessive loss. Furthermore administration of potassium resulted in no evident clinical improvement. In the past potassium has occasionally been used more or less empirically in this disease along with the major therapy, the anticholinesterase drugs.

There appears to be more than a coincident association between myasthenia gravis and heart disease. Several cases with myocardial involvement have been reported,[1] the histologic picture ranging from focal atrophy to extensive necrosis of muscle cells, some with interstitial infiltration of chronic inflammatory cells, leading to death in cardiac failure. In most instances a thymoma was present and similar histologic changes were found in skeletal muscle. Fatty infiltration with fibrosis and degeneration of the myocardium has also been reported,[2] along with various cardiac arrhythmias, conduction abnormalities and cardiac enlargement attributed to distention of a myocardium which has lost its tone. It may well be that some of the deaths ascribed to "respiratory paralysis" in myasthenia gravis patients are in reality due to cardiac failure, as apparently occurred in this case. Unfortunately the neurological manifestations of the disease are so prominent and their therapy so specific and dramatic that attention is readily diverted from other symptoms.

A systematic evaluation of the cardiac status of patients with myasthenia gravis would seem to be warranted.

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Drug therapy of hypertension—J. H. Moyer and A. N. Brest. Arch Intern Med 108:231 (Aug.) 1961.

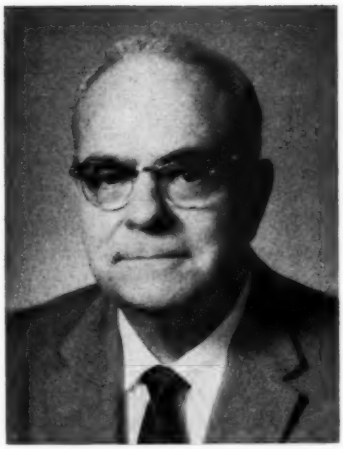
The use of ganglionic blocking compounds in combination with Rauwolfia and chlorothiazide proved to be an extremely effective method of blood pressure reduction in patients with moderate and severe hypertension. The concurrent use of Rauwolfia and the thiazide derivative significantly potentiated the antihypertensive effectiveness of the ganglioplegic drugs and also diminished the incidence and severity of accompanying side reactions. Subjective improvement occurred in most instances after significant blood pressure reduction was accomplished. In addition, associated vascular deterioration was generally arrested and objective improvement was often noted. Improvement in renal function was variable. When there was ample reserve, the effect of ganglionic blockade in depressing renal vasospasm often increased renal function; but kidney function was sometimes further impaired when the renal status was borderline. The most important aspect of therapy with ganglion blocking agents is effective dose titration. Dosage requirements are extremely variable; therefore "average" doses are frequently ineffective in individual instances.

Improper attire of surgeons: A means of contamination. Editorial. William H. Prioleau, M. D. (Charleston), *The American Surgeon* 1961, 27:561.

Careless attire and improper dress of surgeons, as noted in operating rooms and medical illustrations, must be considered a cause of hospital acquired infections. The floor is now recognized as an important reservoir of pathogenic micro-organisms which are spread by personnel, inanimate objects and air. As the surgeon, more than most other personnel, comes into contact with infectious cases on the wards and in the office, he should take particular precautions not to be a means of cross contamination. The scrub suit should be freshly laundered, the scalp hair covered in front and back, the mask effective, and the shoes clean or overshoes worn. The scalp hair should be adequately trimmed, the finger nails short, and the skin free of pyogenic infection. The article is supported by photographic illustrations of the incorrect and the correct attire.

Of general interest about the eyes. J. W. Jervey, Jr., M. D. (Greenville) Tri-State M. J. 9:6-7, May 1961.

A case is made for the toughness of the eye as against the usual conception of its fragility. The importance of glasses is minimized, as it should be. The general practitioner is urged to recognize and treat the simpler eye conditions while a few warnings are given regarding the referral of the more serious conditions which should be treated by the ophthalmologist.



President's Page

You know that not many of the professions enjoy the freedom that the doctors of America do. I wonder if you have ever taken the time to stop and think of the many things that you can do without any restrictions whatsoever. Certainly the unions do not have this privilege, for they are restricted by the number of hours that they can work, the membership in the union is more or less compulsory, your privileges are determined by the union, and the amount that you can even make. Of course, in medicine you belong to your various societies, starting at the county level, but then there is not a "mop-up squad" that is going to force you to join. You work as hard or as little as you desire, make as much as you want and charge what you think the service is worth. Perhaps this last statement is the most misused and abused of all the freedoms that we, as doctors, enjoy. It is not generally abused and not misused by the majority, but the minority that do abuse and misuse, paint the picture that all doctors of medicine are sometimes accused of resembling.

There are other things that a minority of the doctors have done, and in some cases are doing, that reflect on the majority, and this is most unfortunate, but as long as the majority go about doing the good that they do, being honest in their work, and to their patients, I believe that we can and will continue to have these freedoms that we enjoy now. However, they will not continue to exist, unless each individual takes it upon himself to see that medicine's IMAGE (if you care to call it that) is the reflection of you and all the other doctors like you, who are trying to deliver the best and most conscientious service to the patients that they serve, and at the most reasonable cost that is possible to do this service.

I may be wrong, but it seems to me that it was Patrick Henry that said; "The price of Liberty is eternal vigilance". This applies to the practice of Medicine as well as any other profession, for the deprivation of your freedom in the selection of your patients, the choice of treatment, and the pursuance of continued learning, would be the most disastrous catastrophe that could befall this profession that we, and our predecessors, have loved and worked for so well.

Charles N. Wyatt, M. D.

Editorials

PROFESSOR OF SURGERY

Doctor Frederick Evert Kredel, master surgeon, professor of surgery, is dead.

The loss to the Medical College of South Carolina and to the State and its people as a whole is not to be taken lightly; he will not be readily replaced.

A mild mannered and soft speaking man, his qualities, accomplishments and value were fully known and acknowledged by his close colleagues of the faculty and in foci over the state and the nation, but they were not publicized by him. A man of absolute integrity, with a breadth of knowledge and experience not limited to the immediate area of his professional work, he was of quiet and unassuming nature. Withal, however, when the chips were down he never left doubt as to his position. When he spoke it was with authority, and was so taken. He tended to hew straight to the line; expediency was not in his vocabulary.

A native of Pennsylvania, a Master of Science at the University of Pittsburgh, a Doctor of Medicine at Johns Hopkins University, a finished surgeon at the University of Chicago, he came to the Medical College of South Carolina in 1937, as its first full-time academic career faculty member in surgery. There he began the organization of a modern teaching service and the training of surgeons through a four-year apprenticeship in education, research and preparation for the practice of surgery. From a beginning of one resident trainee, who will be remembered as Dr. Horace G. Smithy, of pioneer heart surgery reputation, the pupils of Dr. Kredel are now well scattered as leading surgeons over South Carolina and over the country. The residents in that postgraduate training service now number ten or more annually, not including those in the surgical subspecialties.

As head of the department of surgery and chief of that major service in all of the clinic and hospital activities of the Medical College, Dr. Kredel was the guiding light in the planning and organization of that area of the Medical College Hospital when it was built. When it opened for service as a medical school teaching, service, and research hospital in 1955, he came into his full and well earned opportunity. As the fates would have it, hard upon the maturing of his plans and success in developing one of the outstanding surgical departments of the country, the tragedies of his life beset him. A series of physical misfortunes struck separately although perhaps connectible, the last one finally fatal. Being a man of unbending determination, he would not give up to the several disabling physical mishaps, any one of which might have stopped one of less character and stamina. His death occurred when by his own decision he was seeking a measure of rehabilitation that proved a forlorn hope.

Dr. Kredel was a scientist in the true sense.

Not only was he active from the beginning in surgical research, but even at the moment of the final fatal issue he had secured outside financial aid in an important research project. He was not merely an investigator himself; he inspired his pupils and associates to research thinking and habits. Never a prolific writer of papers merely for the publicity of appearing in print, he nevertheless has very creditable standing in surgical research publications. A member of virtually all regular medical societies and an active participant in many programs, he attained high office in a number, notably the American College of Surgeons, and he belonged in the inner portals of perhaps the most exclusive organization in his career field, the Society of University Surgeons.

Although he may be classed as a bold surgeon, that position was always based on sound knowledge, judgment and a reasonable prospect of helping the patient. His services were never denied; when there was adequate reason he would operate, without regard to his "mortality statistics." Never a believer in high fees, the fee schedule which he guided into effect would not be subject to the criticisms nowadays leveled promiscuously at the medical profession.

The life and works of Dr. Kredel, the position that he occupied, as the first career academic surgeon at the institution he helped to build, the relations and the regard that he held with students, assistants, associates and colleagues of the profession, as well as the affection in which he was held by many people indebted to him, even the tragical misfortunes he suffered, may well make of him a legendary figure in the story of the Medical College of South Carolina. What he did and what he stood for were not buried with him.

Kenneth M. Lynch

PARATHION POISONING

Parathion is now used in many parts of the world in agricultural operations, and many cases of poisoning and not a few deaths have been reported from its use. In Japan particularly there have been thousands of cases and hundreds of deaths. Treatment until this time has been largely with atropine and largely unsatisfactory. While atropine is still considered a valuable drug in parathion poisoning, the need for a substance which would reverse the harmful process induced by parathion has been evident, and now an antidote appears to have been found in the form of pralidoxine chloride, known more simply as 2-PAM. Its action consists in the rapid regeneration of cholinesterase whose action has been previously inhibited by parathion or similar preparations.

*The New England Journal of Medicine** reports in detail a case in which atropine and 2-PAM were used quite successfully. It is probable that the value of this latter drug is known in poison control centers, but a somewhat more general familiarity with it might result in a reduction of the dangers from toxic amounts of parathion.

**New Engl. J. Med.* 265:436

FEES FOR RESIDENTS

New suggested solutions to the problem of attracting competent people into the study of medicine seem to be coming along fairly fast. A recent proposal emanating from the Student AMA and others more mature suggested that very material increases be made in the salaries paid to members of hospital house staffs so that they would not have to go through that penurious period which is now necessary to all except those who are independent financially. As a means of attracting resident staffs, this has its virtue, but it also has its vice as far as hospital financing is concerned.

Now a suggestion comes along from an eminent educator, chairman of the AMA Council on Medical Education and Hospitals, to the effect that residents should receive fees for treatment of paying patients in hospitals. Actually, New York County Medical Society has approved Blue Shield payments to licensed residents in an effort to solve the financial and teaching-patient crisis in medical education. Perhaps if this becomes a general practice it might serve to provide funds to make up the desired salaries suggested by the Student AMA.

Nowadays hospitals have relatively few strictly indigent patients as compared with some years ago, and many of the part-pay or not completely private patients have insur-

ance and other ways of meeting medical obligations. In some places it is customary for insurance and other fees derived from such patients who are not full private patients to be put into a fund which is used for the benefit of the house staff, but this fund is not usually disbursed in the form of direct payments.

To the old line practitioner this latter broad suggestion of payment to house officers by patients may seem a bit radical. He cannot but look on this arrangement as something that will be competitive for the patient's dollar, and he may not wish to turn the complete handling of his patient, both medical and financial, over to the house staff if there is any other way out. Perhaps there isn't, but it is likely that the suggestion will receive some debate.

Whether or not the arrangement proposed would mean any material loss to the practitioners in a community where hospitals are active would be a pertinent question. As a possible field, let us consider one community where there are hospitals employing 65 residents and 33 interns. There are 140 actual practitioners in the immediate area. In various connections they utilize the hospitals for their own patients. Would the addition of 65 or perhaps 98 potential hospital practitioners make a material difference to the 140 local practitioners who might have the need and the wish to obtain what fees they properly can from their normal group of patients?

This is an interesting thought, but will certainly bear discussion before it is adopted generally. Qualifications might well be in order before consideration of the application of this method.

CORPORATE PRACTICE

There is quite a bit of talk now about the financial advantages of corporate medicine. Already in four states this form of arrangement has been approved for any group of three or more doctors, and it is quite possible that this system of practice may extend widely in those states in which it becomes approved by state law.

A corporation gives the opportunity to secure the equivalent of social security benefits, a tax sheltered pension plan and various fringe benefits. It does not involve any change in the professional activities of the participants, and it should always be under strictly medical control. The benefits to be derived may extend to all of the corporation's employees, nurses, administrative aides and so on under certain provisions.

This is an alternate plan for the Keogh Bill which is intended to provide eventually the same kind of savings, but this would give a broader benefit and perhaps a better financial return. It has even been suggested that one doctor might be incorporated, but this thought has not been pursued to a definitive ruling.

Incorporation will not affect the practice of medicine, nor the professional liability of the individual participant. The AMA has given approval to the principle, and model acts have been drawn by the AMA Law Department which might be used by those physicians who are concerned with promoting the legal blessing of incorporation in their own states.

UNFORTUNATE TITLES

Some of the titles of our medical papers are so involved and so long that they are hard to understand and certainly must play hob with the unfortunate cataloger's peace of mind. About this one, however, there can be little doubt, but it could make your blood run cold. The title; "The Urethral Catheter, a Two-Edged Sword", and this is a true one.

THE DOCTORS

by

T. Hood

The honors which to kings we give
  to doctors also paid:—
We're the kings subjects while we live—
  The doctors when we're dead.
Tho' when in health and thoughtless mood
  We treat them oft with scoffing;
Yet they returning ill with good,
  Relieve us from our coughing (coffin).
At times they kill us to be sure
  In cases rather fickle—
But when they've killed—they still can cure
  Their patients in a—Pickle.
And when at last we needs must die—
  The doctors cannot save
From Death—they will most kindly try,
  To snatch us from the grave.

News

DR. CHARLES WYATT IS HONORED FOR MEDICAL WORK; TRAY IS PRESENTED

Citing outstanding personal characteristics of sincerity, honesty, forthrightness, temerity and a willingness and desire to stand up for what is right, Greenville County doctors and guests paid tribute to Dr. Charles N. Wyatt at a dinner in his honor.

Dr. Wyatt, noted Greenville physician and surgeon, was honored for his tireless efforts on the part of organized medicine at the dinner meeting of the Greenville County Medical Society at the Poinsett Club. Several out-of-town doctors attended the dinner to add their support to the testimonial.

A handsomely engraved silver tray was presented to Dr. Wyatt by the society as a token of esteem.

Its inscription read:

Presented to Charles Newton Wyatt, M. D.; Physician-Gentleman; Colonel, Medical Corps A.V.S., 1942-46; Councilor of Fourth District, 1950-59; Chairman of Council, 1958-59; President of S. C. Medical Association, 1961-62; An outstanding and forthright leader in the highest tradition of our profession. . ."

Dr. John Webb was in charge of the dinner and termed Dr. Wyatt a "prophet who is with honor in his own country." He cited his tireless efforts on behalf of the medical profession and noted that as president of the state association "We could not have selected a man who would have given more."

Dr. Wyatt, speaking to the group prior to the presentation commented:

"I want to let you know that any honors which may be done to me tonight should be reversed. What has been done and accomplished over the years has been through help and assistance."

He added: "You have always stood steadfast—and it is I who should be honoring you."

Dr. Thomas Brockman, Dr. J. D. Guess, Dr. Lee Milford of Clemson, Dr. Henry Ross, Dr. J. E. Crosland, were among doctors who added their words of praise for the noted medical man.

And at the end of the meeting, Dr. Wyatt, smiling, noted that "I am glad you came here to praise Caesar and not to bury him."

A FIGHTER FOR BETTER MEDICINE

The medical profession of South Carolina honored itself and its desire for self-improvement the other night when it paid fitting tribute to Dr. Charles N. Wyatt of Greenville, president of the South Carolina Medical Association.

The occasion was a dinner given in his honor by the Greenville County Medical Society and attended by leading physicians from over the state. The token of appreciation was a handsome silver tray engraved with a part of the record of Dr. Wyatt's contributions to the profession outside of his extensive personal prac-

tice. We say "part" of the record because there wasn't room on the big tray for all of it and much of it couldn't be described anyway.

We first knew Dr. Wyatt when he was staff physician at Furman University. For years he was a familiar sight on the sidelines at Furman's football games, checking every player as he came off the field and closely scrutinizing every sprain or other sign of injury. He may not be as fast on his feet now as when he used to dash out on the field, but he has lost none of his energy and drive.

The public little knows it, but members of the medical profession, despite the natural professional jealousy which no group of human beings can escape, are constantly trying to improve their knowledge, exchanging ideas and indulging in searching self-criticism. When they meet for their technical sessions, in which case histories play a big part, no topic is taboo, no technique safe from questioning and no personality immune from criticism.

Seminars of doctors, both general practitioners and specialists, have become more frequent in recent years, ranging from local to statewide and regional meetings sometimes attracting scores of doctors from several states. Dr. Wyatt has been a prime mover in most of these and has led many of them. They are productive, else the doctors wouldn't take time to attend them in the numbers they do.

All of this is aimed at helping and encouraging the doctors to bring their knowledge up to date and to improve their skills to the end that the public is better served. This sort of activity has become almost an obsession, it seems, with Dr. Wyatt.

As president of the state medical group, he has traveled form one end of South Carolina to the other speaking to gatherings of doctors, nurses and laymen. He has sought to help the public understand better what it can and can't expect of its doctors and nurses and has exhorted his colleagues to greater zeal in their ministrations to the public.

And "Dr. Charlie" is not one to pull his punches, soft-pedal the unpleasant or obscure and excuse shortcomings.

We join in the salute to Dr. Wyatt and in doing so we express gratitude to the other dedicated members of his profession.

Greenville News
Oct. 6, 1961

DR. WYATT ADDRESSES WOMAN'S AUXILIARY

Dr. Charles N. Wyatt addressed the September meeting of the Advisory Board of the Woman's Auxiliary in Charleston. Dr. Wyatt, who is a member of the AMA's Disaster Medical Care Committee, discussed the problems of medical care in a disaster such as a nuclear attack. He emphasized the need to get doctors to set up on the local level a training program for medical and lay personnel.

AN ADDRESS TO THE WOMAN'S AUXILIARY

C. N. WYATT, M. D.

In attempting to try and find a subject that would be appropriate it seems to me that the two most pertinent matters at this time are—the participation of the medical profession in politics and the organization and promotion of emergency medical care in the crisis that face this country and the world today.

The participation of physicians in politics has been very negative until the past few years, when legislation on the state, and especially the national level, has forced the profession out of their political lethargy and demanded that they arouse not only members, but the American public to the danger facing this nation, for not only are these changes to the profession, but to the way of life that we have known and enjoyed all these years. Each year for the past three years or more, there have been introduced into the Congress of this Country some 300 to 500 bills that pertain in some respect to the practice of medicine. Out of these hundreds of bills only a comparative few have to be acted upon by the AMA in the interest of medicine. Contrary to the off-stated remark "The AMA is opposed to everything" many of these bills are endorsed and supported by the AMA. However, all of these bills are studied as to their effect on medicine, and then a decision is made as to the action the AMA will take.

An article appearing in the Denver *Post* of 17 September, 1961, states that, and I quote:

"To fend off such plans, the AMA set up a lobby in Washington. Today, of a general Washington staff of 25, there are four registered lobbyists: a doctor, a lawyer and two former newspapermen.

"In moments of crisis in the past, the AMA has registered as many as eight lobbyists.

"Every day when Congress is in session, a staff member pores over the Congressional Record, noting bills of possible interest to doctors.

"Within three days the AMA has copies of those bills. They are analyzed by a lawyer. Six times a year the 12-doctor Committee on Legislative Action meets to advise the AMA's course on these bills.

"The AMA may do nothing. Or it may offer data. Or it may offer to testify for or against. In cases close to the AMA's heart—notably anything that smacks of "socialized medicine"—the lobbying staff goes to work.

"Member doctors in states are mobilized to work on public opinion at home, to wire their own congressmen, or to send messages to friends in Congress."

This same article stresses the fact that a large percent of the members of the House of Delegates (68) are 55 years of age or older, and that only 26% of the AMA members at large are in this age bracket. This is not, in my opinion, a power political machine, but indicates to me the lack of interest of the membership at large and the younger members in particular. I would, therefore, like to impress on you, the wives,

to see that your husbands take an interest, and maintain this interest, in the activities of their county society, their state association and the AMA.

This interest must be maintained for a solid front must be presented by the medical profession. I say this because of the days ahead. In the "Legislative Roundup" (published by communications section of the AMA) of September 8, 1961, the warning is sounded of a tough year ahead, and I quote:

"Tough Year Ahead—The medical profession and its allies in the battle against a compulsory social security approach to health care of the aged face a very tough year—There will be new and increased pressures during the election year of 1962 to enact the King bill (H.R. 4222) and only an all-out effort at the local and national level will defeat it—Portent of things to come were rife during the past week.

"Highest Priority—On September 1, President Kennedy promised to ask Congress to place the "highest priority" next year on an aged care program financed by the compulsory social security system. The President gave this assurance to Sen. Pat McNamara (D., Mich.) in a letter responding to a request from McNamara for such an expression — Kennedy told the Senator: "I wholeheartedly agree with your belief in the importance of this legislation to our nation. I assure you that I intend to recommend that this legislation be given the highest priority at the next session of Congress." — The President said he was "convinced that only the social security system can furnish satisfactory protection against the costs" that illnesses present to persons over 65 — In his letter of appeal to the President, McNamara explained that a strong presidential endorsement for an aged care bill "would serve to stimulate a prompt beginning to the planning" needed if the bill is to be enacted in 1962.

"Javits Jabs—On September 5, Sen. Jacob Javits (R., N. Y.) took the President and the Administration to task for failing to take action on H.R. 4222 or other legislation on health care of the aged during the First Session of the 87th Congress — Javits urged that the Congressional recess of 1961 be utilized for the purpose of meetings between Democrats and Republicans for the development of a compromise bill for medical care for the aged — Javits, who reasoned that Republican support would be necessary for any aged care bill, listed the following probable compromises: (1) cover all aged, not merely those on social security; (2) provide for preventive care — this to include physicians' services; (3) a plan whereby beneficiaries of voluntary health plans would be permitted to continue such plans as an alternative to accepting benefits under a Federal bill — Javits attacked the Kerr-Mills program as being entirely inadequate — He concluded by urging that the President give his entire support to a bill providing for medical aid to the aged and that the program be the first bill called up in January, 1962.

"Newspaper's View—Meanwhile, the *Wall Street Journal* carried a feature article by Staff Reporter John A. Grimes which began: ' "Chances are growing that Congress next year will approve the hotly controversial plan for medical care for the aged via Social Security. Passage, if it comes, will not be easy. Because of the cost, backers may have to settle for a cut-down version of President Kennedy's present scheme to pay hospital, nursing-home and other bills for 14 million Americans aged 65 or more." '

"Summing Up—New pressures will arise for passage of H.R. 4222 or bills similar to it, and political writers will predict passage of a medical aid plan under social security — But remember this: There were tremendous pressures for passage of the Forand bill and several newspapers predicted its enactment—The Forand bill failed to pass, and the King bill will also be defeated if the medical profession and its allies wage a vigorous and intelligent fight."

And I may state that we have some very strong allies in this fight such as Chamber of Commerce of U. S., Farmers' Bureau, National Association of Manufacturers, and others.

There are other forms of legislation affecting the medical profession such as scholarships for persons studying medicine — health insurance for retired federal employees — U. S. Commission on Aging — establishment of a military medical college — factory inspection and drug amendments — compulsory coverage of physicians under Social Security — and "Coon-Skin Cap" Kefauver's bill for Licensing of Prescription Drug Manufacturers — (S-3677) and many, many others.

Is there any wonder that there is alarm within the ranks of organized medicine about the reduction of application to study medicine?

This could go on and on, but I wish to make a few remarks about the Emergency Medical Care or Disaster Medical Care. Having just returned from a meeting of the Committee on Disaster Medical Care of the AMA, there are certain things that are alarming concerning this phase of American preparedness. As you know, there has been a change in the so-called Civil Defense set-up in that the President in an appearance before Congress on 25 May, 1961, stressed the justification of Civil Defense as needed insurance for the country against the hazard of an atomic war. (This could happen by accident or by an enemy's miscalculation or insanity.) He further reorganized the set-up by placing the defense of the civilian population under the care of the Department of Defense. He stated that a nation-wide program to provide fallout shelters in new and existing buildings will be started, and that three times as much money (294 million) would be sought for the promotion of this plan. Also, private citizens and local and state governments will have to share the cost."

The AMA recommended a shelter program as far back as 1957 and has been urging the government to take the lead in this matter, over the years. To no avail. The same is true of gas masks. (It is known by Intelligence that the Russians have and are prepared to wage both bacterial and chemical warfare.)

Surely the Civil Defense is a responsibility of the

government, but certain responsibilities befall the individual as well. The responsibility of the medical care is certainly a responsibility of the medical profession and it is its duty to see that there is organization and training not only among the physicians, which is sadly lacking, but among the allied medical personnel—dentist, vet, nurse, pharmacist, technician. The people are looking to the doctors for leadership, and this leadership *must* be provided through leadership, instruction and organization.

The AMA through its Council on Security and its Committee on Disaster Medical Care has long been advocating preparation along these lines. Close liaison has been had with the old office of CD and the PHS and certain accomplishments have been made. Among them is the distribution of the 200-bed Emergency Hospitals, which have been distributed to every state in the union, (S. C. has 24), a plan of survival that has been written in each state, Civil Defense Directors of states, and last but not least, a Self Help Survival Kit which is in the process of being distributed in the near future. (This is to have trial at Brooklyn, Battle Creek and Alameda, California during the month of October.)

This consists of lectures in control of bleeding, sanitation, hygiene, care and feeding of babies, and has full instructions for the instructor and a projector and slides. It is written so that a person of a 9th grade intelligence can understand. It is planned that 100,000 will be trained the first year (1962), 300,00 the next year (1963) and a million by 1964. Other means of promoting Disaster Emergency Care are advocating tetanus toxoid and keeping this up-to-date, blood banks, typing of blood, etc.

C. N. Wyatt, M. D.

Dr. Samuel D. Campbell

Dr. Samuel D. Campbell, the oldest member of the Greenville Medical Society, was recently featured in a newspaper article with his reminiscences of fifty years of medical practice. Dr. Campbell received his medical degree from the University of Georgia in 1902. He practiced in Piedmont from 1909 until 1952 when he moved to Greenville where he maintains a small office in his home.

Besides the great difference in transportation, both roads and vehicles, Dr. Campbell recalled the lack of hospitals in the early years of his practice and the doctor's responsibility for preparing and supplying much of the medicine he prescribed. Dr. Campbell was also called upon to perform dental services. He has made over 6,000 deliveries and remembers vividly the time he brought four babies into the world within a 24 hour period. Dr. Campbell now serves as mill doctor for the Piedmont Plant of J. P. Stevens Company, Inc. and keeps office hours at the plant for an hour daily.

Dr. Peter Gazes, assistant professor of medicine (cardiology) at the Medical College of South Carolina spoke on "Bedside Clues in the Diagnosis of Cardiovascular Disease" at the First Charlotte Postgraduate Seminar at Presbyterian Hospital in Charlotte on October 18.

Appointment of Dr. John W. Berg as editor of "Cancer — A Journal of the American Cancer Society," a publication devoted to clinical and basic research, was announced recently by the American Cancer Society.

Dr. Louis Palles has been certified as a Diplomate of the American Board of Obstetrics and Gynecology, an organizatien to encourage study in the two fields. Dr. Palles a graduate of Davidson College and University of Pennsylvania Medical School is in practice in Florence with Dr. Harry Temple.

Dr. John M. Ervin, Jr. announces the association of Dr. J. K. Newsom in the general practice of medicine. Ervin-Newsom Clinic, 148 2nd Street, Cheraw.

Dr. Newsom did his pre-medical work at the Citadel, received his M. D. degree from Tulane Medical School, and recently completed his internship at McLeod Infirmary.

ROPER GETS FOURTH ARTERY STUDY GRANT

The fourth research grant by the John A. Hartford Foundation, Inc. of New York to Roper Hospital has been announced by Ralph W. Burger, president of the foundation, and C. A. Robb, administrator of Roper Hospital.

The new grant provides support of $160,297.00 to cover a project period of three years (July, 1961 to June, 1964). An additional $10,000 is being made available for special equipment which will be needed in the new studies.

With the present grant, Roper Hospital has recevied a total of $392,633.00 from the Hartford Foundation. The first grant was received in 1956. The present funds are being used for the investigation of diseases of the arteries and the development of new diagnostic methods and new treatments of arterial obliterative diseases.

The program is under the direction of Dr. J. Manly Stallworth, director of the Vascular Laboratory and assistant professor of surgery at the Medical College of South Carolina. The studies are being accomplished cooperatively at Roper Hospital and the Medical College.

The conclusions drawn from laboratory studies under earlier grants are being used in the medical and surgical treatment of patients. Also the latest principles of diagnosis and treatment are being used for teaching medical and nursing personnel.

Woman's Auxiliary

Meeting in Charleston on September 22, board members of the Auxiliary to the S. C. Medical Association voted to support the 16th annual national essay contest sponsored by the Association of American Physicians and Surgeons. Greenville physician, Dr. Thomas Parker, is state chairman for the contest.

Also at the morning session, auxiliary members heard a report from Civil Defense committee chairman, Mrs. Ralph B. Baker, Newberry. Mrs. Baker called for members to work toward the goal of informing and training families, adding that such training would be the determining factor in survival of atomic war.

Mrs. John T. Cuttino, Charleston, president of the auxiliary, termed civil defense as "one of our gravest concerns."

Two committees were appointed during the morning board meeting. Elected to a convention committee for the annual 1962 meeting at Myrtle Beach were Mrs. L. C. Martin, Charleston, chairman; Mrs. Ralph Baker, Newberry and Mrs. R. G. Slocum, Columbia.

Elected to a nominating committee for the current year were Mrs. George Smith, Florence, chairman; Mrs. George Orvin, Charleston and Mrs. Robert Thompson, Union.

Mrs. Cuttino announced that all auxiliary members are invited to attend the annual Southern Medical Association convention in Dallas, Texas November 6 through 9.

A special guest at the session was Dr. J. I. Waring, Charleston, public relations chairman for the Medical Association. Dr. Waring spoke to the group on the state-wide speakers bureau, asking auxiliary members' support of the bureau's program in their communities.

Guest speaker at the luncheon was Dr. Charles N. Wyatt, Greenville, president of the S. C. Medical Association. Dr. Wyatt discussed the participation of the medical profession in politics and the organization and promotion of emergency medical care in the crisis that faces this country and the world today.

COLUMBIA MEDICAL SOCIETY

The Columbia Medical Society will hold its Annual Meeting for the Election of Officers at the Hotel Columbia, Monday, December 11, 1961. Present officers are: Dr. Weston C. Cook, President; Dr. Joe E. Freed, Vice-President; Dr. James T. Green, President-Elect; Dr. Charles R. Sloan, Secretary; Dr. Waitus O. Tanner, Treasurer; and Dr. P. F. LaBorde, Editor of THE RECORDER.

Dr. Harold E. Jervey, 1515 Bull Street, Columbia has been appointed Secretary-Treasurer of the Federation of State Medical Boards and Editor of the Federation Bulletin.

DR. LETA J. WHITE IN AFRICA

Dr. Leta J. White, former part-time clinician of the Cherokee County Health Department, has resigned in order to serve in the Baptist Medical Center in Ghana, West Africa. She was to leave October 2 and will return April 1, 1962.

Dr. Pickens K. Moyd, a native of Greenwood, has opened his office for the practice of general surgery in Hartsville. Dr. Moyd is a graduate of the Medical College of South Carolina and took his internship and residency training at the Medical College of Virginia Hospitals in Richmond.

Deaths

DR. F. E. KREDEL

Dr. Frederick E. Kredel of 60 Montague Street, Charleston, S. C. died October 8.

Dr. Kredel formerly was head of the department of surgery at the Medical College of South Carolina. He came to Charleston in 1937 from the Chicago Clinic. He was a graduate of Johns Hopkins University. He was active in the American College of Surgeons and held several offices in that organization.

Dr. Kredel's last project was extensive research into fat embolisms. He specialized, however, in abdominal surgery.

A former president of the Charleston County Medical Society, Dr. Kredel had a narrow brush with death in early January, 1957. He entered the Medical College Hospital after recurrent attacks of gastro-intestinal upset and suffered a serious rupture of the aorta, the heart's major blood vessel. A staff surgeon at the hospital performed an emergency operation on Dr. Kredel and removed the ruptured section of the aorta. The removed section was replaced by a plastic vessel. The delicate operation took five hours, and one of the attending physicians said afterwards that the staff surgeon's skill very likely saved Dr. Kredel's life.

In April of 1953, Dr. Kredel was honored by the American Cancer Society. He was awarded a medal for being the "outstanding contributor to the state's 1952 cancer program."

During his tenure as head of the Medical College's Department of Surgery, Dr. Kredel performed a number of rare operations. He received national recognition for successful operations on "stroke" victims who were paralyzed from lack of blood flowing to the brain.

On March 23, 1956, a portrait of Dr. Kredel was presented to the Medical College of South Carolina by Dr. Alton G. Brown of Rock Hill. Dr. Brown made

the presentation on behalf of surgery residents trained under Dr. Kredel, who was the first full-time professor of surgery at the Medical College Hospital.

DR. E. A. SIMMONS

Dr. Elbert A. Simmons, 80-year-old Timmonsville physician, died October 6 of injuries received in an automobile accident.

Dr. Simmons attended Cokesbury Conference School and received his M. D. degree from the University of Louisville in 1909, starting his practice in Timmonsville the same year.

Dr. Simmons practiced medicine for 42 years in Timmonsville and 10 in Hemingway. He served as president of the Florence Medical Association and also as secretary-treasurer of the Williamsburg Medical Association.

DR. HERBERT E. VAUGHAN

Dr. Herbert E. Vaughan, 69, retired physician of South Weston St., died July 30 after three months illness.

He was a native of Timmonsville and had practiced medicine in Fountain Inn for the past 20 years.

Before coming to Fountain Inn, Dr. Vaughan had practiced at Reidville in Spartanburg County. He was a graduate of the University of South Carolina and the South Carolina Medical College in the class of 1911.

DR. J. CLYDE MOORE

Dr. J. C. Moore practicing physician of the Duncan community for 50 years, died at his home following three years' illness.

He was born and reared at Lake City and was a graduate of the Medical College of South Carolina, class of 1901. He did post-graduate work at Polyclinic Institute in New York. He was an honorary member of the American Medical Association and the S. C. Medical Association and was an active member of Spartanburg County Medical Society.

He was the first practicing physician for Pacific Mills at Lyman and for a number of years was surgeon for the Piedmont and Northern Railway and was physician for Duke Power Plant at Duncan.

Announcements

SYMPOSIUM ON USE AND ABUSE OF ANTIBIOTICS

A Circuit Course of the Division of Postgraduate Education of the Medical College of South Carolina. Under the auspices of the Third District Medical Society.

GREENWOOD, SOUTH CAROLINA
Self Memorial Hospital
December 5, 1961 — 6:00 - 10:00 P. M.
Dinner — 7:00 to 8:00 P. M.
Faculty:
Louis Jervey, M. D.
Margaret Jenkins, M. D.
Louie B. Jenkins, M. D.

R.S.V.P.
Dr. Paul Garrison
Greenwood
South Carolina

COURSE IN LARYNGOLOGY AND BRONCHOESOPHAGOLOGY

April 2 to 14, 1962

The Department of Otolaryngology, University of Illinois College of Medicine, will conduct a postgraduate course in Laryngology and Bronchoesophagology from April 2 through 14, 1962, under the direction of Paul H. Holinger, M. D.

Registration will be limited to fifteen physicians who will receive instruction by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures.

Interested registrants will please write directly to the Department of Otolaryngology, University of Illinois College of Medicine, 1853 West Polk Street, Chicago 12, Illinois.

PAN-AMERICAN MEDICAL CONGRESS

The VIII biennial Congress of the Pan-American Medical Women's Alliance will meet in Manizales, Colombia, South America, February 17-24, 1962. Women physicians of North, Central and South America are cordially invited to attend this Congress.

A pre and post Congress tour has been arranged from New Orleans, leaving February 7, 1962 and returning March 11, 1962. For further information for those making the tour, please write to Eva F. Dodge, M. D., 2124 West 11th Street, Little Rock, Arkansas.

Civil Defense

CIVIL DEFENSE

The U. S. Public Health Service has announced plans to train 60 million Americans in basic medical procedures that would be of value in a national disaster, such as an all-out nuclear attack.

Jerrold M. Michael, assistant chief of the Health Mobilization Division of PHS, said the program, called "Medical Self-Help Training," will begin this fall.

The program is designed to give one person in each family 12-16 hour courses in such basic medical skills as radiation fallout protection, hygiene, sanitation, treatment of fractures and common infectious or epidemic diseases, infant and child care and even emergency delivery of babies.

Although sponsored by PHS, the program will be carried out by state Civil Defense directors and state health departments.

This unique training program is keyed to prepare the American people to care for themselves where necessary by their own ingenuity and with the resources they may have on hand at the moment of disaster.

A key figure in the training program will be the practicing physician. He will be asked to advise and provide the professional leadership so necessary for the successful accomplishment of this training program.

To assist physicians and to do the actual instruction in most instances, the support of all other health professionals, allied health workers and individuals with previous experience in this type of teaching is necessary.

The Medical Self-Help Training will teach persons confidence in their ability to survive, along with the skills to make them self-reliant until they can obtain a physician's services.

During October, November and December three Medical Self-Help Workshops will be held in Brooklyn, N. Y., Alameda, Calif., and Battle Creek, Mich. Some 100 professional health personnel and civil defense and education leaders will attend each workshop for orientation in the proposed program.

It has been proposed that within each state a Medical Self-Help Committee be established to advise civil defense directors and to provide professional leadership to the program. It is recommended that the committee consist of the State Civil Defense Director, State Health Officer, State Chief School Officer and representation from the State Medical Society.

From inception of the research project, the American Medical Association, through its Council on National Security and Committee on Disaster Medical Care, provided guidance, counsel and review of all plans, actions and materials concerned with the medical self-help program.

HEALTH MOBILIZATION AND DISASTER MEDICAL CARE

The threat of nuclear warfare with its capability of mass destruction of huge elements of our nation has imposed on the medical and allied health professions of this country a tremendous responsibility in the nation's efforts to survive. Never before in history has the productive individual assumed such importance as he is expected to assume in modern warfare. The saving of lives particularly of those who can contribute to the survival efforts, has become extremely important and the medical and allied professions must assume a far larger role in our war potential than ever before. They face their greatest challenge. In view of the critically important role that organized medicine in all its phases must play, prior, during and subsequent to a mass attack on the United States, a national plan, far reaching in scope, adequate in concept, permanent and flexible in nature, and wholeheartedly supported by the medical profession, is an absolute incontroversial and immediate necessity if this country is to survive such an attack—and live to fight back.

The role of the medical profession is to prepare its members to cope effectively with the results of a mass attack on the United States and to assist actively in preparing the nation to withstand such an attack. In the event of a mass attack on this country, the role of the medical profession is to provide to the nation the highest quality and best organized remedial and preventive medical services possible, in order that maximum numbers of physically and mentally fit survivors imbued with high morale and a courageous spirit are and will become available to assume their share of responsibility in the ensuing national recovery efforts and to participate in concurrent and subsequent combat operations. It is expected

that professional medical associations will actively encourage and provide the necessary leadership in supporting such approved professional and technical training programs as may be designed to ensure the medical preparedness of the state and nation for an all-out war. It is further expected that individual physicians will assist, advise, and conduct training sessions when requested, demonstrate their assumption of leadership in the field of disaster medicine and ensure adequate and proper instruction of the general public.

BLUE CROSS . . . BLUE SHIELD

A WORD TO DOCTORS— FROM A DOCTOR

By R. L. Schaeffer, M. D.

Thirty or more years ago, a group of low income teachers, in Texas, realized that they needed some plan of prepaid hospital and medical care.

The idea spread rapidly, and today almost 57 million people in the United States and Canada are covered by Blue Cross, for hospital bills. And Blue Shield, for doctor bills, has 47,000,000 members.

These prepaid plans spread rapidly because there was no other plan or any kind of insurance to provide the same or as great benefits. Blue Cross and Blue Shield plans believe that health care financing, organized as a community service and *not* for profit, is in the best interest of subscribers, doctors, hospitals and the general public.

The goal of these plans is *service* rather than profit. The concern is *protection*, rather than cost. Should Blue Cross and Blue Shield ever fail, in my opinion, there will be Government control of medicine.

Hospitals and the doctors can prevent their failure by curtailing the costs of hospital and medical care by adhering to the following *Don'ts*:

1. DON'T put a patient in a hospital bed just because he wants to be there or because it is more convenient for the doctor to have him there.
2. DON'T order expensive services that are not really needed just because the patient thinks he needs them and they won't do any harm—and, besides, he is covered by insurance.
3. DON'T order a patient admitted on Saturday when nothing is going to be done for him until the doctor visits him Monday. In this respect, pre-admission laboratory testing would be very helpful.
4. DON'T have a patient put in a hospital bed purely for diagnostic purposes that can be accomplished as easily or better in the out-patient department or the office of a specialist.
5. DON'T hold up a patient's discharge because of his family's convenience or for some other relatively unimportant reason.

It is quite easy, of course, to tell a doctor what *not* to do. There are pressures upon him from his patients. The doctor is in business for himself and unless his patients like him they will choose another physician. But until better public attitudes are adopted by many *doctors* we are not even going to get our feet wet in reducing or holding the line in the costs of health care.

It requires a strong professional conscience on the part of the physician to resist pressures by the patient.

Hospital administrators must rely on you to forestall unreasonable demands. Explain to the patient that, either through ignorance or indifference, he is acting against his own ultimate self-interest by raising today's hospital costs even higher.

Point out to him that by taking up a hospital bed unnecessarily he may prevent the admission of someone who is critically ill, and that some day the tables might be turned on him.

Appeal to his pride by pointing out that by calling upon a hospital for unnecessary service, he is really asking someone else to shoulder his bills, since hospital and insurance rates are based on over-all expenditures.

A progressive step by Blue Cross has been the introduction of its Co-Pay Comprehensive contract, based on the co-insurance principle. (I know something about these things because I serve on a Blue Cross Board of Directors.)

This agreement with the subscriber, also directed in part toward eliminating unwise hospitalization, offers the highest in in-patient benefits as well as out-patient diagnostic service but *does* require hospitalized patients to pay a modest daily payment out of their own pockets. There is nothing so effective in cutting down unneeded occupancy of hospital beds as placing some of the financial responsibility on the patient.

The function of the hospital in the community is, of course, to take care of sick people when they are sick enough to require hospital care. Hospitals are primarily service institutions and the ace in the hole that hospitals have is that there always will be hos-

pitals. They may be financed or organized in some other way than now, but they will always be here.

Blue Cross, however, is a secondary community service organization solely for the purpose of perfecting the voluntary method of financing hospital care.

Blue Cross is not an insurance company. It uses some of the averaging principles of insurance but it is not insurance as such. Its purpose is still what it originally was—to provide a voluntary means for a whole community to finance hospital care for the whole community. The fact that we have not yet reached the ideal or the ultimate does not invalidate the objective.

We should not run away from the fact that Blue Cross is "social" insurance. Social insurance is a nasty word in many circles, but we cannot run away from it because it is the nature of the problem.

The object of all of us—doctors, hospitals and Blue Cross—is not to preserve hospitals and Blue Cross. It is to promote the health of the people.

There are factors which affect the cost of medical care that cannot be controlled by Blue Cross, Blue Shield, hospitals or doctors. One of these is *medical progress*. New techniques, new methods, new equipment, and the use of special services—all the services the public wants and demands—have to be provided within reason. Blue Cross and Blue Shield want to provide them and the subscriber ultimately has to pay for them.

May I ask the hospital and the doctors not to abuse Blue Cross and Blue Shield so that these plans can continue providing all the hospital and medical services at a cost which the public can afford!

ANNUAL REPORT
1960-1961
CHILD EMOTIONAL AND MENTAL DEVELOPMENT COMMITTEE

KENNETH AYCOCK, M. D.

In its first year of conception the Child Emotional and Mental Development Committee thought that they could best serve the South Carolina pediatricians by acquainting them with the large number of both emotionally disturbed and mentally retarded children, and with letting them know the facilities available in South Carolina for the treatment of the emotionally disturbed and mentally retarded child.

I. *EMOTIONALLY DISTURBED CHILD.*

The facilities available for the treatment of the emotionally disturbed child are largely through the South Carolina Mental Health Commission. Prior to 1961, there were (5) clinics operated by the State Mental Health Commission. The General Assembly in 1961 approved the Community Mental Health Services Act which allows for: (1) The participation of all counties in mental health services; (2) Local control and initiation of services with state control; (3) State Grants-in-Aid on a 50-50 basis for community services, and (4) The creation of Area Mental Health Boards with administrative responsibility for community mental health services in multi-county units. For the purpose of extending services to all counties, the state has tentatively been divided into 10 areas, on a population basis, each with its own clinic. Six of these clinics are now in operation:

Greenville County Mental Health Clinic
600 County Office Building
Greenville, South Carolina
Dr. Iverson O. Brownell, Director

Charleston County Mental Health Clinic
275 Calhoun Street
Charleston, South Carolina
Dr. R. Ramsey Mellette, Jr., Director

Spartanburg County Mental Health Clinic
149 E. Wood Street
Spartanburg, South Carolina
Dr. Samuel R. Kilgore, Director

Richland County Mental Health Clinic
1845 Assembly Street
Columbia, South Carolina
Dr. James E. Gilbert, Director

Darlington-Florence County Mental Health Clinic
P. O. Box 1568, Dr. George W. Houck, Director

York-Chester-Lancaster Mental Health Center
1051 Oakland Avenue
Rock Hill, South Carolina
Dr. W. G. Morehouse, Director

It is expected that 2 new clinics will open within the coming year, one in Greenwood and the other in Anderson. It is hoped that the remaining two clinics allocated for Aiken and Horry or Georgetown county will be forthcoming within the near future.

As to the out-patient care of the emotionally disturbed individuals seen in these clinics, the South Carolina Mental Health Commission has broken down their statistics into those persons below and those persons above 18 years of age. In 1958, there were a total of 493 patients under 18 years of age whose treatment was terminated in the 5 clinics then in operation. In 1959, there was a total of 521 children whose treatment was terminated, and in 1960 there was a total of 491 children whose treatment was terminated in the 5 state clinics. Although there does not seem to be much, if any, increase in the total patient number over the three year period, it is of interest to note that in all three years those patients under 18 years of age represented approximately one-half of the total patients terminated.

Another service provided by the South Carolina Mental Health Commission is the mental health education unit. Much fine work is being done by this division, and they are more than happy to extend their services to anyone interested.

As of this date, there are no facilities available for the residential treatment of emotionally disturbed children in South Carolina. However, there are psy-

chiatric units at several hospitals throughout the State where emotionally disturbed children may be hospitalized. At the Medical College Hospital there is a close working relationship between the department of psychiatry and department of pediatrics and the local Mental Health Clinic. Of the total 491 terminated patients under 18 years of age seen in all the mental health clinics in South Carolina, 25 were institutionalized.

The type of service rendered to those terminated patients of 1960 under 18 years of age is given in table below:

Diagnosis and Treatment	125
Diagnosis only	196
Psychological Testing Only	35
Other Service	131

The source of referral of those terminated patients of 1960 under 18 years of age was as follows:

		Sex		Age Group	
	Total	Male	Female	Under 18 years	18 yrs. & over
Schools	91	61	30	80	11
Physicians 36.1%	398	163	235	165	233
Health & Welfare Agencies	157	70	87	77	80
Self	152	56	96	9	143
Family	120	76	44	89	31
Courts	60	40	20	34	26
Ministers	30	18	12	8	22
State Institutions	12	3	9	4	8
Other	81	32	49	25	56
Total	1,101	519	582	491	610

II. *MENTALLY RETARDED CHILD*

Various studies in the United States show that 3% of the population is mentally retarded. A further breakdown shows out of each 1,000 persons, 30 are mentally retarded—25 of whom are educable, 4 trainable, and 1 totally dependent. Based on these studies, it is assumed that South Carolina, with an estimated population of 409,469 under 7 years of age, has 12,284 mentally retarded children in this age group.

Mental retardation is by far the most crippling condition which affects our nation's children. Of each 100,000 persons in our population, an estimated 200 are blind, 300 are permanently crippled by polio, 350 by cerebral palsy and 700 by rheumatic heart conditions but 3,000 are mentally retarded.

There are at present in South Carolina 2 centers for the evaluation of the mentally retarded child: The Child Development Clinic, Pediatric Department, South Carolina Medical College, and The Evaluation Clinic for Mentally Retarded Children located at 1515 Bull Street, Columbia, and under the administration of the Maternal and Child Health Division of the South Carolina State Board of Health. Both have long waiting lists with no apparent hope for immediate relief of this condition.

The Child Development Clinic in Charleston accepts patients on referral of licensed medical doctors for two indications, namely: (1) Diagnosis of cases who are not functioning adequately in comparison with their peers, and in whom the reason for the inadequate function is not entirely clear; (2) Children who are not functioning adequately because of either an established diagnosis of one of the causes of mental retardation, or because of obvious emotional problems, the primary purpose of the referral being further evaluation and counselling regarding medical, psychiatric, educational, or custodial plans with parents who have difficulty accepting the obvious diagnosis.

The Evaluation Clinic for Mentally Retarded Children in Columbia has been in operation since May, 1961, and is set up for the purpose of comprehensive diagnostic study and evaluation of any child under 7 years of age whose development reflects some degree of mental retardation.

In addition to the 2 clinics mentioned, other facilities for the mentally retarded child in South Carolina include wonderful help and guidance for the parents of these unfortunate children through the various parent organizations for the mentally retarded. There are a total of 9 such organizations in the state:

AIKEN Chapter
Mrs. J. M. Weibel
1215 Lake Avenue
North Augusta, S. C.

EDISTO Chapter
(Orangeburg, Bamberg, Calhoun)
Mrs. Harry Arrant
Box 181
Orangeburg, S. C.

CHARLESTON Chapter
Mrs. Arthur Ravenel, Jr.
P. O. Box 3141, St. Andrews Br.

COLUMBIA Chapter (Richland)
Mrs. Julius Green
4144 Shorebrook Drive

GEORGETOWN Chapter
Dr. John T. Assey, Jr.
122 Orange Street

GREENWOOD Chapter
Mrs. T. H. McNeill
317 W. Cambridge Avenue

MARLBORO Chapter
Mr. Brantz Mayer
Oakdale Court
Bennettsville, S. C.

SUMTER Chapter
Mr. Robert Newton
Sumter County Mental Health Project

GREENVILLE Chapter
Mrs. Ray L. Hayes
Taylors, S. C.

The extent to which the needs of the mentally retarded are presently met in this state can be divided into residential facilities, and public educational services. The residential facilities include Whitten Village for the white with a population of 2,273, and Pineland for the colored, with a population of 404.

Both schools are filled over their expected quota and have long waiting lists. The services offered through the Public Education Department are 137 and 53 special classes in public schools for the educable retarded white child and negro child, respectively.

There are 7 special classes for the trainable retarded white child, 1 each in Charleston, Columbia, Georgetown, Greenville, Sumter, 2 in Aiken, and 1 special class for the trainable retarded negro child in Georgetown.

It is hoped that there will be the addition of one special class for the educable retarded colored child in Columbia this fall.

Hope for the crying needs of the mentally retarded child in this state hangs on the work of the legislative committee of Mental Health and Mental Institutions whose Chairman is Senator Earle E. Morris. It is hoped that with the coming legislative year means will be provided for additional special educational classes, the establishment of local special classes for the trainable retarded child, and within the not too distant future, the development of a retarded children's school and rehabilitation center, with the addition of increased housing space for institutionalized patients.

RECOMMENDATIONS BY THE COMMITTEE

1. The committee strongly urges each pediatrician who has a mentally retarded child in his care, to encourage the parents of these mentally retarded children first to have an evaluation at one of the clinics mentioned and, secondly, get in touch with a local chapter of the Association for Retarded Children. If there is no local chapter, then much help can be given both the parent and the child by contacting the South Carolina Association for Retarded Children.
2. Acknowledge the splendid work accomplished by the Legislative Committee of Mental Health and Mental Institutions under the directorship of Senator Earle E. Morris.
3. The committee would like the chapter to recognize and report the work being done by the study committee on emotionally disturbed children of the South Carolina Mental Health Association with regard to obtaining a resident treatment center.
4. The committee would like the secretary to write the South Carolina Mental Health Association to send a copy of the new directory of Mental Health Resources in South Carolina to all pediatricians.

IMITATION SPECIALTY BOARDS

(Reprinted with permission from the May 1961 issue of the *Archives of Environmental Health.*)

It is the ironic fate of many articles of excellence that they stimulate the production of imitations. Some imitations have real merit and value; others are of questionable worth. Imitation specialty boards present some interesting phenomena, particularly in relation to the causes and effects of their existence.

In the present era of status symbols it is clear that certification by a specialty board represents a fine example of the genre. Since symbolism is involved it is the appearance that is important. A well-contrived imitation may have the same value as the genuine thing.

The scandalous proliferation of medical diploma mills during the latter part of the 19th century and their disastrous effects on medical education are familiar history. The American Specialty Boards, established for the purpose of raising standards of medical practice, may now be facing a similar threat. The imitators are at work.

Presumably it is not illegal for any group of individuals to band together and call themselves an American Board of whatever they may choose. Such groups will probably be careful not to adopt the name of a previously existing Board, but there may be close resemblance. If someone wanted to organize an American Board of Medicine or an American Board of General Surgery it is unlikely that very much could be done to prevent it. The general public and perhaps some physicians might not recognize that these Boards were not of the same type as the American Board of Internal Medicine or the American Board of Surgery. How many people know about the Advisory Board for Medical Specialties and its role in the certification of specialists?

In the eyes of many persons the terms Occupational Medicine and Industrial Hygiene are synonymous. The certification of physicians as specialists by an American Board of Industrial Hygiene can hardly be welcomed with joy by those physicians who have been certified as specialists in Occupational Medicine by the American Board of Preventive Medicine.

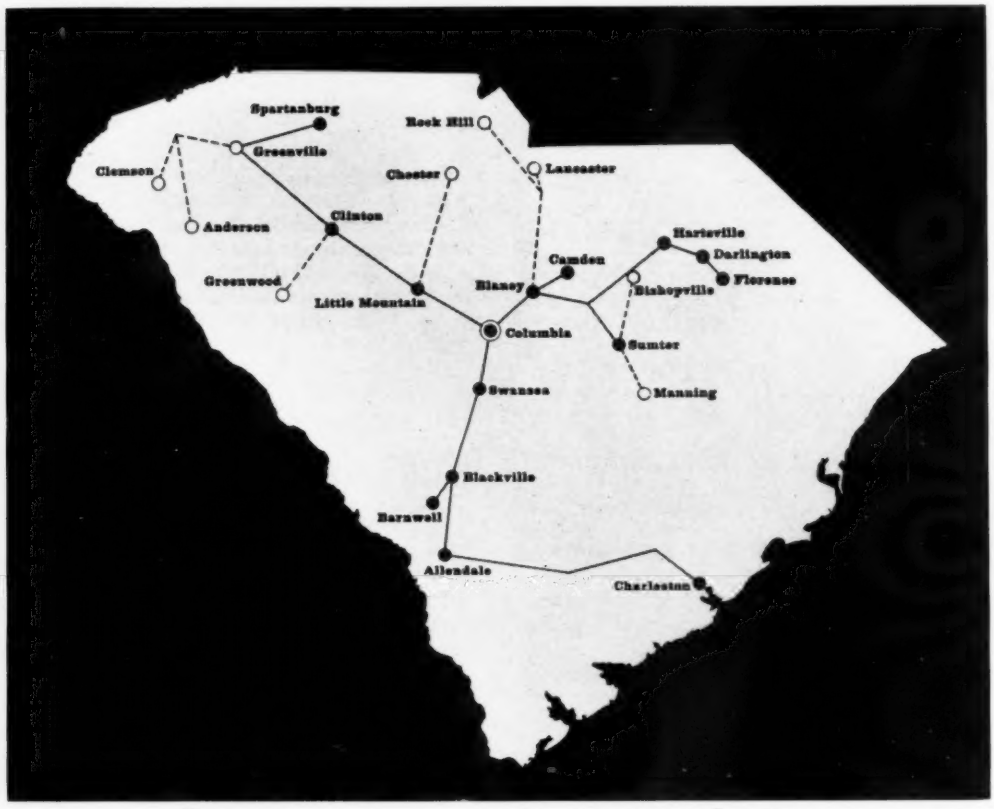
Why would a physician wish to be certified by an American Board of Industrial Hygiene when he has available to him certification in occupational medicine by the American Board of Preventive Medicine? One possible answer comes readily to mind: He was not able to meet the high standards of professional achievement required by the latter. If this be true it logically follows that some physicians may be willing to settle for a second-class type of certification rather than none at all. In the eyes of some this may give the second-class diplomate the status he seeks, but to his more sophisticated colleagues he has identified himself as a second-class specialist.

If acceptance of an inferior type of specialty certification were purely a personal matter, it would obviously be highly improper for an outsider to criticize or interfere. But just as the existence of inferior medical schools formerly threatened the quality of medical education in the entire country, so an inferior specialty board threatens the quality of medical practice. If a cheap imitation will do, why bother with the genuine article?

What has been said above is meant to apply only to physicians. The nonmedical industrial hygienists are

to be commended for their efforts to elevate their own professional standards. Possibly their objective might have been achieved by creating a Fellowship category in their professional society. Better still, they might have striven for recognition through the existing American Board of Preventive Medicine. Since physicists are certified by the American Board of Radiology it is quite possible that biochemists, toxicologists, and others may be able to work out a similar arrangement with the American Board of Preventive Medicine.

Leonard J. Goldwater, M. D.
New York



WHITE DOTS INDICATE CITIES THAT JOINED THE NETWORK THIS SEPTEMBER.

INAUGURATION OF
MEDICAL TV IN SOUTH CAROLINA

DALE GROOM, M. D., CHAIRMAN,
COMMITTEE ON POSTGRADUATE
EDUCATION, MEDICAL COLLEGE
OF SOUTH CAROLINA

On November 30, 1961, the first of a series of medical television programs directed to physicians of South Carolina will be presented over the State's closed circuit Educational Television system. The network, (Fig.1), now linking 62 schools in 21 counties with its central studios in Columbia, is the first statewide educational TV circuit in the United States. Likewise a "first" is this application of the facilities for postgraduate medical education.

The programs will consist of 1 hour symposia on various medical subjects of interest to practicing physicians, and will be produced by faculty members of

the Medical College of South Carolina in collaboration with the ETV staff in Columbia. Each symposium will be followed by a 30 minute question and answer period during which viewing doctors may telephone questions in to the panel and thus participate themselves in this new type of state-wide medical meeting.

Because the programs are transmitted over a closed circuit system they cannot be seen by the public on home TV receivers. Rather, they will be viewed by groups of physicians who go at prearranged hours to any of the schools listed below. This is the same Educational Television circuit which is used during school hours to teach thousands of students courses ranging from algebra to science and history, which grew from a one-city network in 1959 to its present state-wide proportions and which, within a year or two, will probably link every county in South Carolina. Appropriation by the State legislature for ETV for the 1961-62 school year is $798,600. This medical application of the vast system is, essentially, an extra dividend in that it utilizes existing facilities during evening hours.

Initially, these symposia will be presented from 8:00-9:30 P. M. on the schedule below. Each will be recorded on TV tape and shown over the same network the following evening for physicians who were unable to attend the live performance.

"THE DIFFERENTIAL DIAGNOSIS OF CHEST PAIN"
Thursday, November 30
Friday, December 1
"HEADACHE"
December 14, 15
"THE LUMP IN THE BREAST"
January 4, 5, 1962

Subsequent programs will be announced in later publications. All may be viewed at any of the following schools:

ALLENDALE
Allendale Training School
ANDERSON
Westside High School
McCants High School
BARNWELL
Barnwell High School
Butler High School
BISHOPVILLE
Bishopville High School
Dennis High School
BLACKVILLE
Blackville High School
Macedonia High School
BLANEY
Blaney High School
CAMDEN
Camden Junior High School
Camden Senior High School
Jackson High School
CAYCE
Brookland-Cayce High School
CENTRAL
Daniel High School
CHARLESTON
Rivers High School
Simonton High School
CHARLESTON HEIGHTS
Chicora High School
CHESTER
Chester High School
CLEMSON
Calhoun-Clemson Elementary School
CLINTON
Clinton High School
COLUMBIA
A. C. Flora High School
Booker T. Washington High School
C. A. Johnson High School
Columbia High School
Crayton Junior High School
Dentsville High School
Dreher High School
Hand Junior High School
DARLINGTON
Brunson-Dargan High School
Saint John's High School
Mayo High School
FAIRFAX
Allendale-Fairfax High School
FLORENCE
McClenaghan High School
Paynor Junior High School
Southside High School
Wilson Senior High School
GREENVILLE
Parker High School
Washington High School
GREENWOOD
Brewer High School
Greenwood Senior High School
HARTSVILLE
Hartsville High School
Hartsville Junior High School
LANCASTER
Lancaster Senior High School
MANNING
Manning High School
Manning Training School
PICKENS
Pickens High School
PROSPERITY
Mid-Carolina High School
ROCK HILL
Emmett Scott High School
Rock Hill High School
Winthrop Training School
SPARTANBURG
Carver High School

Cleveland Junior High School
Cumming Street Junior High School
Frank Evans Junior High School
Jenkins Junior High School
Roebuck High School
SUMTER
Alice Drive Junior High School
Edmunds High School
McLaurin High School
Lincoln High School
SWANSEA
Swansea High School

Officials of these schools have been informed of the inauguration of medical TV programs. It is suggested that groups of physicians in each locality served make their own arrangements with them for viewing in the schools. The responsibilities of production and transmission of programs rest with the Medical College and ETV stays, but responsibility for local arrangements must remain with local medical organizations.

HILL-BURTON IN SOUTH CAROLINA

Since 1947 over $80.5 million have been spent in South Carolina for the construction of hospitals and medical facilities. Nearly $38 millions of this amount came from grants-in-aid under the federal Hill-Burton program.

Pictured on this page are five of the buildings erected with these funds. These represent three of the categories under which the construction is allowed, namely mental and general hospitals and health centers.

Orangeburg County Health Center, Orangeburg—Hill-Burton public health center opened in 1959. *Federal share* $93,730.54 *and total facility cost* $187,461.09.

In the field of mental illness only 1/5th the estimated number of needed hospital beds are available. Remedial action in this area is now being taken inasmuch as the last General Assembly of our state appropriated funds for construction of such facilities to be supervised by the South Carolina Mental Health Commission. The current trend is to develop psychiatric facilities in general hospitals, rather than to concentrate all available mental hospital beds in one state hospital. In South Carolina five general hospitals now have psychiatric units, these being in Anderson, Spartanburg, Greenville, Columbia and in the Medical College Hospital in Charleston.

Spartanburg Mental Health Clinic, Spartanburg. An out-patient clinic building constructed under Public law 482 (*an amendment to the Hill-Burton Program*) *and completed in* 1958 *at a cost of* $50,000.

Fairfield County Memorial Hospital, Winnsboro—Hill-Burton 25 *bed hospital opened in* 1955. *Federal share* $337,341.65 *and total project cost* $528,362.15.

*Intensive Treatment Facility at State Hospital (James F. Byrnes Hospital and Clinic Building), Columbia—*200 *bed hospital opened in* 1959. *Federal share* $414,714.56 *and total project cost* $2,571,326.41.

Clarendon County Memorial Hospital, Manning—Hill-Burton 52 *bed hospital opened in* 1954. *Federal share* $189,651.84 *and the total project cost* $575,765.52.

Future grants will undoubtedly be used for projects to provide nursing home care and care of the chronically ill. According to statistics of the U. S. Public Health Service, which administers Hill-Burton funds, South Carolina has a woeful deficiency of nursing home and chronic disease beds, the met needs in these fields being approximately only 14% and 6%, respectively.

MEDICO

What is MEDICO? Its purpose, needs and organizational set-up were explained by Dr. Peter Commanduras, its co-founder in 1958 with the late Thomas A. Dooley, M. D., during the course of the 110th annual meeting of the A. M. A. to invited representatives of each of the medical specialty organizations, such as surgeons, radiologists, internists, pediatricians, etc.

The story of the world's medical needs, as told to them by Dr. Commanduras was a grim one. He reported:

1. One half of the people of the world rarely, if ever, in their lifetime have a physician to treat their ills.
2. Malnutrition, vitamin deficiencies and even starvation take an annual toll of millions of children in Asia, Africa, South America and the Carribbean.
3. Readily correctible club feet and other congenital deformities doom tens of thousands of children to go through life as cripples.
4. Trachoma prevention and modern ophthalmological treatment and surgery could save the sight of thousands of persons, chiefly in Southeast Asia, the Middle East and North Africa who face a lifetime of blindness.
5. Diseases that have yielded to modern medical science, such as smallpox, cholera and malaria, still cause millions of deaths annually in these areas.

Substantial progress, particularly in public health, has been made in many nations with the help of the World Health Organization, International Cooperation Administration, and private foundations. These programs, although of the utmost importance, only indirectly touch the lives of the world's sick, blind and disabled. Their need is immediate and personal; their primary interest is not political or ideological. Such words as freedom, justice, dignity and security are meaningless to those faced with the heritage of a life of discomfort or agony.

That something tangible and definitive can be done to reduce suffering on a sufficiently broad scale as to be significant has been demonstrated by MEDICO, which operates under two basic concepts:

1. To bring direct, physician-to-patient medical aid to areas where the need is greatest, treating the sick who otherwise would receive no medical attention.
2. To teach and train others to give this kind of medical assistance.

From one small hospital in Laos in 1958 to fifteen projects in 12 nations currently is evidence of MEDICO'S need and early success. The American physicians who have personally participated in MEDICO'S overseas work on a short-term basis have all been volunteers who have received no pay. Many have paid their own travel and maintenance. Many have contributed their vacation time to this endeavor.

The purpose of the special meeting in connection with the AMA annual session was to invite formal participation by all national medical and surgical societies in the MEDICO program. Under the proposal each specialty organization would be represented on the MEDICO Board of Directors and each would form a special committee to implement the MEDICO program objectives.

The representatives of the specialty societies present as individuals enthusiastically and unanimously endorsed the proposal in principle and agreed to present it to their own organizations for formal action. In view of the importance of the undertaking Dr. Howard A. Rusk writing in the New York Times stated "It is almost inconceivable that any of our major medical and surgical societies should refuse the invitation".

Today more than at any time in our history, the leadership of our nation is challenged. Direct, physician-to-patient services by American doctors offer a proven, effective way by which the sick, blind and crippled of the world may understand in a personal way the value we place on human dignity.

Inasmuch as it will take time to get the program as outlined above worked out and organized, individuals may volunteer by writing Dr. Peter D. Commanduras, Medico, 420 Lexington Avenue, New York 17, New York, or telephone MU 5-8460. Well-trained and well-motivated surgeons, internists, general practitioners and anaesthesiologists are currently needed in Afghanistan, Cambodia, Vietnam, Malaya, Laos, and Haiti. Salaries, length of service and specific information concerning each project will be sent on request.

This article is based on that of Howard A. Rusk, M. D., which appeared in the New York Times, Sunday, July 2, 1961.

"Certainly the Arthritis came back, but so did your check."

Book Reviews

PROGRESS IN MEDICAL GENETICS, Vol. I., Edited by Arthur G. Steinberg. Grune and Stratton, New York and London—1961. Pp. 341. Price $9.75.

This is the first of a proposed series of books designed to help the clinician and others interested in medical genetics "keep up" with the rapid advances being made in this field today. The first volume consists of 8 excellent chapters written by highly competent medical geneticists and physicians. It is not designed for casual reading nor is it designed for the busy practicing physician if he has had little or no training in genetics.

In addition to chapters on mutation, natural selection and congenital malformations in man, the book includes discussions of ABO incompatibility and the relation of these blood groups to such diseases as duodenal and gastric ulcer, gastric carcinoma, pernicious anemia, etc. Hematologists should find the chapter on hemoglobinopathies informative and useful.

Probably the most striking advance in the last 5 years has resulted from a series of discoveries relating observable changes in chromosome number and form with such clinical entities as mongolism, gonadal aplasia, Klinefelter's syndrome and other congenital abnormalities.

Elsie Taber, Ph. D.

THE NATURE OF SLEEP. Ciba Foundation Symposium. Little Brown and Company, Boston, 1960. 416 pp. Price $10.00.

The more advanced technics of neuroanatomy and neurophysiology have been directed toward elucidation of the nature and mechanisms of sleep. This symposium includes a considerable group of European investigators and a few from the United States all of whom have made experimental inquiry in this field. Dr. Nathanial Kleitman, for instance, is known to have spent the better part of an active career in this particular area of study. Their summaries here bring this specialized interest together in an up-to-date convenient form.

R. P. Walton

PATHOLOGIC PHYSIOLOGY — Mechanism of Disease. By William A. Sodeman. 3rd Edition. W. B. Saunders Company, Philadelphia, 1961. pp. 1182. Price $15.00.

This highly readable volume covers the important areas of clinical physiology. Common, routine medical situations are interpreted in terms of recent investigative findings and this is done with a clear incisiveness and very little of the haze which commonly obscures the area between experimental and practical medicine. The reason for unusual clarity and bright gems of interpretation might be found in the qualifications of the 28 collaborating authors. Each combines a background of original experimentation, bed-side teaching and long-time responsibility for patient care. The illustrations are exceptionally effective in transmitting concepts. Any serious reader consulting this volume can be certain to find something both stimulative and informative. Significant new revisions include the section on medical genetics, hemodynamics, neurologic disorders, radioactive exposures and space medicine.

R. P. Walton, M. D.

TRAITOR WITHIN—Our Suicide Problem by E. R. Ellis and G. N. Allen. Doubleday and Company, Inc., Garden City, N. Y. 1961. $3.95.

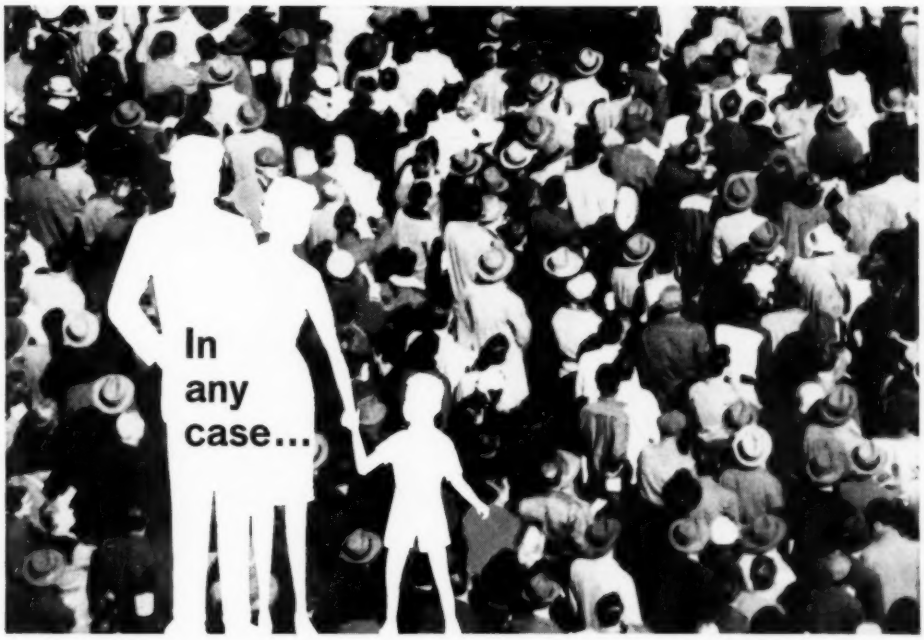
This book treats exhaustively from a statistical point of view the problem of suicide which ranks eleventh in the causes of death in the United States. The authors have been studying the subject for fifteen years and treat it from every conceivable angle—its prevalence, its means, the notes which the suicide leaves, its concept in various civilizations, the ideas on it in our own society, the social losses it entails, ways to attack it. The value of the book in our opinion lies in the two last named areas. The appendix contains a training guide and case form of an experimental suicide-prevention group in Miami, Florida, calling itself FRIENDS. The book is a plea for the recognition of suicide as a health problem and consequent skilled attention for persons threatening to take their own lives, rather than the prevalent disregard or dismissal of the matter as an attention getting mechanism or a passing mood.

M. S. A.

CARDIOVASCULAR DYNAMICS by Robert F. Rushmer, Second Edition. W. B. Saunders Company, Philadelphia and London, 1961. $12.50.

This is an excellent text since it is designed for the first year medical student up to the experienced cardiologist. The illustrations are very good and serve to present concepts in a visualized manner. This makes the reading much easier, especially since graphs and tables have been omitted. Although at times the author's opinion appears dogmatic, this aids in giving the student a background which is not confusing as would be the case if many explanations and hypotheses were presented. This book is unusual as compared to other books in that it presents cardiovascular problems with a clinical and physiological approach. It should be recommended to all individuals who are interested in cardiovascular problems.

P. C. Gazes, M. D.



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G. D. SEARLE & CO.
CHICAGO 80, ILLINOIS
Research in the Service of Medicine

GOOD-BYE, DOCTOR ROCH by Andre Soubiran. Doubleday and Company, Inc., Garden City, N. Y. 1961. $4.50.

Dr. Soubiran of Paris, a man of position and activity in the medical world, has already produced a trilogy of novels known as *Men in White* on medical themes. Translations of these three novels received popular and critical acclaim in the United States. This new work brings out forcibly another phase of medical and psychiatric problems.

Written as a diary, the book tells the story of a man who has allowed himself to be confined in an asylum in order to protect an innocent woman. Gradually by his good conduct he is allowed privileges which bring him into contact and friendship with Dr. Roch, a dedicated physician who is attempting, despite bureaucratic opposition and intramural apathy, to better the conditions of the inmates of a hospital for the insane. The frightful conditions prevailing in the institution are described with gruesome detail. The reader is happy to discover that the scene is laid in 1951, and to be reassured that the depressing picture has been brightened by many needed reforms.

Dr. Roch is the central figure of the book. He becomes involved in a strange triangle which includes the inmate and his faithful and charming wife, but a threat of tragedy for all three is dispelled by circumstances which might best be encountered at first hand by the observing reader of this well written novel.

J. I. W.

HOSPITALS, DOCTORS, AND DOLLARS by Robert M. Cunningham, Jr. F. W. Dodge Corporation, New York. 1961 $6.95.

This is a collection of editorials and short articles by the editor of *The Modern Hospital* magazine. It covers a variety of subjects with which hospitals and its various officials must have concern—costs, prepayment, staffing, public relations, nurses, etc. The tone of the articles varies from the cynical to the facetious, with a healthy accent on the main body of serious comment and exposition without bias.

This is a very readable book, with a light touch, and is eminently eligible for the bookshelf, or rather, the hands and eyes, of anyone interested in hospital affairs (and what doctor should not be!) either as a participant in management or as a consumer of services.

J. I. W.

SYSTEMATIC OBSERVATIONS OF GROSS HUMAN BEHAVIOR By G. R. Pascal and W. O. Jenkins. Grune & Stratton, New York. 123 pages, $4.75.

This is an interesting small book whose main purpose is to develop a technical interest in observing the gross conduct and behavior of individuals in terms of the everyday behavior and activity without reference to the verbal or strictly emotional content of personality. This book is an attempt to experimentally and scientifically place the behaviorism of Watson on a more contemporary setting. The former stimulus-response era of Watsonian behaviorism is brought up to date by employing observations of physical behavior, correlating this with certain gross general responses. The purpose of this study is to emphasize a deeper psycho-dynamic understanding of hitherto ignored behavior or overt gross physically-oriented behavior.

The overall value of this book is to bring into clearer focus the importance of observing how a patient really feels and thinks through his physical manifestations of responses in the environment. The author attempts to employ ten measures of degree of behavior response and also uses 14 basic responses of physical conduct in order to bring out the deeper thinking and feeling pattern of an individual, without employing any particular verbal content.

This book offers a unique study in what is commonly referred to in the psychoanalytic technique as the non-verbal response, which often gives a great deal of meaning much before the actual or unconscious responses are made in interviews and discussions. In simple terms, this book adds a technical method in psychiatric work comparable to what the medical diagnostician does in a very careful, precise physical examination.

This book is particularly valuable to medical students, since it allows them to have a simplified easy approach, by using physical means to understand the deeper underlying thinking and feeling of their patients, without having to be concerned about complex personality theories.

Norton Williams, M. D.

PSYCHOANALYSIS AND SOCIAL PROCESS. Fourth Volume of a series on Science and Psychoanalysis. Edited by Jules H. Masserman, M. D. Chairman of the Publications Committee of the Academy of Psychoanalysis. Grune and Stratton, New York, 1961. 189 pages, $6.75.

This is a short, but rather imposing, volume in which the main emphasis is to explore the possibilities of a closer relationship between cultural anthropology and sociology and the science of psychoanalysis. There are contributions from several workers in the field of anthropology and sociology, notably Drs. LaBarre, Kardiner, Talcott Parsons and Spiegel, whose presentations from their own line of work indicate a very deep interest in a cross-disciplined approach to the fields of anthropology, sociology and psychoanalysis. All of these workers agree, in general, that, up to this time, attempts to explain the meanings of the patterns of culture or group action and its relation to individual development have been made through the use of older psychodynamic patterns of individual personality development.

These writers, in their separate articles, all indicate a need for a clearer understanding of the relationship of newer ideas of personality development to the whole structure of culture and society. This move-

ment in the field of social psychiatry is called the culture-personality movement, and is a relatively new fresh attempt to broaden legitimately and scientifically the horizons of psychoanalysis into all fields of human conduct and action, whether individually or in group form.

This is a particularly interesting group of articles that would be of help to all practitioners of medicine since it encompasses the newer theories of psychoanalytic practice. It is particularly important for its better understanding of the social and cultural features in a person's life; that is vital in understanding the total patient. The disciplines of psychoanalysis and anthropology in this setting become a natural ally of one another and can have very practical meaning in the development of the understanding of the individual in his group relationships.

The rest of the book takes up some special articles dealing with some extended scientific attempts to further develop the technical aspects of psychoanalysis.

This book is a very definite worthwhile contribution to the contemporary forms of psychoanalytic development.

Norton Williams, M. D.

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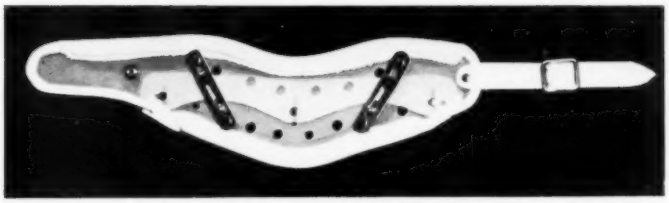

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